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Medicare

Home Health Agency Manual

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U.S. Department of
Health and Human Services
Health Care Financing Administration
HCFA—Pub. 11 (12/85) thru Rev. 176

HE 22.8/5:

This manual has been reprinted to incorporate all revision transmittals issued through the reprint date. It should be noted that the material contained in this reprinted manual is exactly the same as that contained in manuals being maintained by the incorporation of revision transmittals.

Copies of the reprinted manuals should not be ordered to replace older editions.

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HEALTH INSURANCE FOR THE AGED

Home Health Agency Manual

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HOME HEALTH AGENCY MANUAL

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FOREWORD

A. Function of the Home Health Agency Manual.--This manual makes available to the Home Health Agency (HHA), in a form suitable for ready reference, informational and procedural material needed for the prompt and accurate filing of claims for services furnished under the provisions of the Health Insurance for the Aged Act (Medicare). It also contains information the agency may need to answer questions which patients often ask about the program and should help to assure that the law is uniformly applied nationally without regard to where covered services are furnished. The agency's intermediary will issue any necessary additional instructions on matters which concern the relationship between the agency and the intermediary.

B. Contents and Organization.--

1. Contents.--The manual provides instructions for implementation of the provisions of Title XVIII of the Social Security Act and Medicare regulations particularly as they relate to the home health benefits. It amplifies the basic statutory provisions for coverage of services and the requirements which must be met for Medicare payment to be made. The procedures and documentation required have been devised to satisfy the administrative needs of the program and are slanted toward the usual case. However, an attempt has been made to cover some infrequent situations that may occur.

2. Organization.--Four chapters are included in the manual.

a. General Information About the Program.--This chapter contains a brief description of the scope of Hospital Insurance (Part A), Supplementary Medical Insurance (Part B), the requirements for beneficiary entitlement, and a description of the financing and administration of the Medicare program.

b. Coverage of Services.--This chapter details those services reimbursable to agencies under the Medicare program and outlines the requirements for payment.

c. Start of Care Procedures.--This chapter provides detailed instructions for the preparation and submission of start of care notices. It also describes the data the intermediary furnishes in response to the HHA's start of care notice.

d. Home Health Agency Billing Procedures.--Detailed guidelines are provided for completing the Home Health Agency Report and Billing form and the forms Provider Billing for Medical and Other Health Services, and Provider Billing for Patient Services by Physicians.

A table of contents for each chapter provides designated section heads. A detailed index is also included to facilitate locating specific information.

C. Relation Between the Home Health Agency Manual and Other Reference Material.--Title XVIII of the Social Security Act is the statutory basis for the Medicare program and is the foundation for the regulations and all manual material.

The health insurance regulations (HIRM-1) which are furnished to home health agencies are interpretations, implementations, and policies flowing from the statute and are formally approved and published by the Secretary of the Department of Health, Education, and Welfare. Regulations have the force and effect of law and are binding on all parties. The following health insurance regulations may be of interest to HHA's:

Regulation No. 5 Subpart	Title	Section
A	Hospital Insurance Benefits......................	405.101ff.
B	Supplementary Medical Insurance Benefits.........	405.201ff.
D	Principles of Reimbursement for Provider Costs and for Services by Hospital-Based Physicians..	405.401ff.
E	Criteria for Determination of Reasonable Charges; Reimbursement for Services of Hospital Interns, Residents, and Supervising Physicians..........	405.501ff.
F	Agreements with and Functions of Providers, Intermediaries, Carriers, and State Agencies...	405.601ff.
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The Health Care Financing Administration (HCFA) also publishes "Health Care Financing Administration Rulings" containing case decisions and interpretations of the law and regulations. The rulings do not apply to other cases when the facts are not substantially the same.

Although the HHA Manual does not have the effect of regulations, a careful effort has been made to insure that the provisions of the law and regulations are accurately reflected.

The HHA Manual should be used in conjunction with the Provider Reimbursement Manual (HIM-15) which provides guidelines for computing the reasonable costs of services furnished by HHA's and other providers.

D. HHA Manual Revisions.--The manual is designed to accommodate new pages as further interpretations of the law and changes in policy and procedures are made. Accordingly, supplements and revised sections, pages, or chapters are issued as the need presents itself. Changed material is indicated in the left margin of a page in the following manner:

Line on which change begins.

Line on which change ends.

The revision transmittal sheet identifies new page numbers and the pages replaced, and summarises the principal changes in the material being issued. When a major change in policy or procedures is involved, the background and effective date for the change is provided. If, at a later date, you wish to refer to the background explanation given on a transmittal sheet, you can identify the transmittal by its number which appears on each manual page.

E. Use of the Revision Transmittal Check Sheet.--Immediately after the title page, a check sheet has been provided on which receipt of revisions can be recorded. Revised manual transmittals should be filed in transmittal number order to avoid discharding a more recent page in favor of an older one.

If it appears that you have been skipped in the distribution of a particular transmittal, keep in mind that the transmittals are not always distributed in strict numerical sequence. Allow 10 working days after receipt of a higher numbered transmittal before requesting a transmittal that you have not received.

F. Effective Dates for Home Health Agency Manual Issuances.--HHA Manual transmittals specify whether the material involves a change in policy or procedures, new policy or procedures, or simply a clarification of existing policy or procedures. For new policies or procedures or changes in the old, the transmittals also specify the effective date, which indicates at which point in the adjudicative process the policies

apply. New policies or procedures or changes in the old almost invariably carry prospective dates. However, a proposed policy issuance which corrects a prior statement of policy will be given retroactive effect, to be specified on the transmittal.

A clarification is intended only to improve the understanding of policies that are already in effect, and an effective date is not specified.

H. Intermediary as Information Source.--Your intermediary will answer any questions you may have about Medicare policies and procedures. HHA's dealing directly with HCFA may direct questions to the Health Insurance Regional Medicare Director for reply or refer them to the Provider Liaison and Appeals Branch of the Division of Direct Reimbursement.

Check List of Manual Transmittals

HOME HEALTH AGENCY MANUAL REVISION TRANSMITTALS

Use this check list to record receipt of revision transmittals.

Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date
1.	6/66	21.	5/71	41	12-72 ✓	61	3-17-75
2.	2/67	22.	5/71	42	12-7[illegible]	62	3-10-75
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CHECK SHEET FOR HOME HEALTH AGENCY

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Administration of Medicare Program

100. INTRODUCTION

The Health Insurance for the Aged and Disabled Act (Title XVIII of the Social Security Act), known as "Medicare" has made available to nearly every American 65 years of age and older a broad program of health insurance designed to assist the Nation's elderly to meet hospital, medical, and other health costs. The 1972 Amendments to the Social Security Act extended this same health insurance coverage to persons under age 65 qualifying as disabled and those having chronic renal disease. (The term "end-stage renal disease" is the technically accurate term for that state of chronic renal disease which requires a continuing course of dialysis or kidney transplantation to ameliorate uremic symptoms and maintain life. However, since the term "end-stage" may connote a terminal condition to patients, the term chronic renal disease is used with the understanding that the reference is to chronic renal disease which requires hemodialysis or transplantation, as set out in the law.) The program includes two related health insurance programs--hospital insurance (Part A of the law) and voluntary supplementary medical insurance (Part B of the law).

The conduct of the program has been delegated by the Secretary of Health, Education, and Welfare to the Commissioner of Social Security. Congress has provided substantial administrative roles for the States and for voluntary insurance organizations in recognition of their experience in the health care and insurance fields.

The law does not permit the Federal Government to exercise supervision or control over the practice of medicine, the manner in which medical services are provided, and the administration or operation of medical facilities. The patient is free to choose any qualified institution, agency, or person offering him services. The responsibility for his treatment and the control of his care remains with his physician and the hospital or other facility or agency furnishing him services. The individual may keep or obtain any other health insurance he desires.

102. FINANCING THE PROGRAM

Part A (Hospital Insurance) is financed through separate payroll contributions paid by employees, employers, and self-employed persons. The proceeds are deposited to the account of the Federal Hospital Insurance Trust Fund which may be used only for hospital insurance benefits and administrative expenses. The cost of providing Part A benefits to persons who are not social security or railroad retirement beneficiaries is met by appropriations to the Federal Hospital Insurance Trust Fund from general revenues or through premium payments.

Part B (Supplementary Medical Insurance) is financed by the monthly premiums of those who voluntarily enroll in the program and by the Federal Government which makes contributions from general revenues. All premiums and Government contributions are deposited in a separate account known as the Federal Supplementary Medical Trust Fund. Money from this fund may be used only to pay for Part B benefits and administrative expenses.

104. DISCRIMINATION PROHIBITED

Participating providers of services under the hospital insurance program, i.e., hospitals, skilled nursing facilities (SNF's), and home health agencies (HHA's), must comply with the requirements of Title VI of the Civil Rights Act of 1964. Under the provisions of that Act, a participating provider is prohibited from making a distinction on the ground of race, color, or national origin in the treatment of patients; the use of equipment and other facilities; and the assignment of personnel to provide services.

The Department of Health, Education, and Welfare is responsible for investigating complaints of noncompliance.

106. FRAUD AND ABUSE--GENERAL

Fraud in Medicare can be in the form of false claims or bills submitted to carriers and intermediaries for medical or health services which were not rendered. Fraud can also be occasioned by the representation on the claim form of more complicated, and hence more costly, procedures than those actually rendered. Another form of fraud is the submission of a false cost report in which costs are intentionally misrepresented or inflated for the purpose of obtaining Medicare reimbursement not due. It is also fraudulent to engage in kickback arrangements in connection with the furnishing of covered items or services.

The term "abuse" is used to describe incidents and practices which, although not considered fraudulent acts, may directly or indirectly cause financial losses to the Medicare program or to beneficiaries and their families. One type of abuse which occurs often in the Medicare program is overutilization of medical and health care services. The Medicare law expressly excludes from coverage any services that are not reasonable and necessary for the diagnosis or treatment of illness or injury. It is considered abuse when there appears to be a definite and repeated pattern of overutilization. Not all incidents of abuse are considered violations in the legal sense and are often disposed of by corrective action by contractors, plus recovery of any overpayment which has resulted.

106.1 Penalties for Fraud and False Reporting.--Whoever knowingly and willfully makes, or causes to be made, a false statement or false representation of a material fact with respect to the conditions and operation of a health facility to permit the facility to qualify and participate as a provider under title XVIII (either in initial certification or recertification) shall be guilty of a misdemeanor punishable by a fine of up to $2,000, or imprisonment for up to 6 months, or both.

Whoever knowingly and willingly makes or causes to be made any false statement or misrepresentation of a material fact in any application for any benefit or payment under the Medicare program, or makes false statements for use in determining rights to such benefit or payment, or has knowledge of the occurrence of any event affecting the right to receive such benefits and fails to disclose such event with the intent to improperly secure benefits when none is due or receive a greater amount than is due, or receives such benefits on behalf of another and converts them to a use other than for the use or benefit of such person, shall be guilty of a criminal offense punishable by fine or imprisonment, or both.

In addition, whoever furnishes items or services and who solicits, offers, or receives any kickback, bribe, or rebate of a fee, shall be guilty of a misdemeanor punishable by a fine of up to $10,000, or imprisonment for up to 1 year, or both.

106.2 Definition of Key Terms.—In determining whether there has been a violation of any statute, there are several terms which must be well understood before they can be applied to a particular act or acts.

A. Intent to Defraud.—The terms "with intent to defraud" and "fraudulently" are synonymous. They refer to an intentional deception or misrepresentation which the individual knows to be false, or which he does not believe to be true, and which he makes knowing that his deception could result in some unauthorized benefit to himself or some other person. The requisite intent is present if the representation was either knowingly false or made in reckless disregard of what the facts might be. Since fraudulent intent, as a subjective element of crime, is difficult to prove by direct evidence, it may be inferred from circumstances and from patterns of actions. Intent to defraud may be imputed to a corporation if an agent of the corporation has such intent in committing the act. Thus, there would seem to be no legal obstacle to successful prosecution of a corporation provided that: (1) the guilt of the individual acting on behalf of the organization can be established; and (2) the act was committed by the individual while performing within the scope of his employment by the corporation.

B. Knowingly.—The term "knowingly" as used in a criminal statute generally means that state of mind which exists when the accused person is in possession of facts under which he is aware that he cannot lawfully do a particular act, but nevertheless proceeds to do it. It is intended to exclude unwitting or unconscious actions contrary to the law, such as mistakes of fact or accidents.

C. Willfully.—The term "willfully" means voluntarily, purposefully, deliberately, and intentionally as opposed to accidentally, inadvertently, or carelessly. It involves actual knowledge of the existence of a legal obligation and the intent to evade that obligation.

D. Material.—The term "material" as applied to a false statement, false representation, or deceitful withholding of information where there is a duty to disclose the truth, means that the deceit must relate to a matter that is of significance and would tend to influence a carrier or intermediary to pay benefits not authorized by the Act, or would otherwise influence a carrier or intermediary in determining rights to, or amount of, payment. The courts have said that the tests of whether a statement is material is the capability of the statement to mislead, rather than whether it was possible for the intended deception to attain its end.

108. FEDERAL GOVERNMENT ADMINISTRATION OF THE HEALTH INSURANCE PROGRAM

The Department of Health, Education, and Welfare has overall responsibility for administration of the hospital insurance and voluntary supplementary medical insurance programs. Four major agencies of the Department—the Social Security Administration, Public Health Service, Social and Rehabilitation Service, and the Regional Divisions of Long Term Care—are involved.

108.1 The Social Security Administration's central office is responsible for policy formulation and that office, along with its regional offices, is responsible for the general management and operational aspects of the program. Briefly, these include: determination of the individual's entitlement to benefits and the nature and duration of services for which benefits may be paid; establishment, maintenance, and administration of agreements with State agencies, providers of services, and intermediaries; in consultation with the Public Health Service and the Social and Rehabilitation Service, the formulation of major policies regarding conditions of participation for providers (except SNF's); the development and maintenance of statistical research and actuarial programs; and the general financial management of the program. SSA also makes determinations of reasonable costs and amounts to be paid to providers who have elected to deal directly with the Government.

108.2 The Public Health Service has the principal responsibility for the professional health aspects of the program. These include professional consultation and recommendation to the Social Security Administration in development of health and safety, and other guidelines for determining whether providers of services meet the conditions of participation under the program; consultation and advice to State agencies concerning the application of standards for providers, and in the coordination of program activities with other health services and activities in the State; and activities necessary in studying the utilization of hospital and other medical care services under the program.

108.3 The Social and Rehabilitation Service has a primary role in hospital and medical insurance program planning, coordination, and evaluation in matters that affect other federally aided assistance programs; in assisting State agencies to achieve a coordinated approach with other medical care plans under the Social Security Act; and in all aspects of program administration affecting public welfare agencies.

108.4 Regional Divisions of Long Term Care.--Each regional office of the Department of Health, Education, and Welfare (DHEW) has a Division of Long Term Care with authority to approve Medicare provider agreements with skilled nursing facilities (SNF's) and to terminate (or decline to renew) agreements when the SNF's do not meet the standards established by the Social Security Act. The divisions interpret and enforce Federal standards which govern the quality of health care and the safety of patients in skilled and intermediate care facilities.

110. HEALTH INSURANCE BENEFITS ADVISORY COUNCIL (HIBAC)

The Health Insurance Benefits Advisory Council is a nongovernmental advisory group consisting of persons outstanding in hospital, medical, and other health activities, and at least one representative from the public. HIBAC provides advice and recommendations to the Secretary on general policy in administering the Medicare (title XVIII) and Medicaid (title XIX) programs.

112. STATE AGENCIES

The States, by agreement with the Secretary, are assigned significant administrative functions to the extent that each is willing and capable of discharging such responsibilities.

A. Certification.--Facilities desiring to participate in either the Medicare or Medicaid program must meet the conditions of participation to be certified. State agencies make certifications to the Department of Health, Education, and Welfare (DHEW) indicating whether hospitals, skilled nursing facilities, home health agencies, independent laboratories, portable X-ray facilities, and providers furnishing outpatient physical therapy and speech pathology services satisfy, and continue to satisfy, their respective conditions of participation in the Medicare and Medicaid programs. Suppliers of end-stage renal disease services must meet the conditions described in the Federal Register of June 3, 1976--Renal Disease--Implementation of Coverage of Suppliers of End-Stage Services. The Secretary, DHEW, certifies facilities requesting participation in both the Medicare and Medicaid programs, while States certify those facilities that request participation in the Medicaid program only.

The State function of making certifications is intended to be a natural adjunct to ongoing State activities, such as the licensing of health care facilities and the setting of standards.

B. Consultation with providers of services that need and request assistance to meet the conditions of participation is an integral part of the certification process. For Medicare program participation, the Secretary, DHEW, must approve the consultation service rendered by the State certifying agency.

C. Coordination by the State relates its activities in the performance of its functions under the program to the other programs in the State that have to do with payment for health care, quality of care, and distribution of health facilities. Coordination of these activities is essential in assuring effective and economical use of existing State facilities and trained personnel, and to prevent duplication of effort.

D. State Agency as a Medical Insurance Intermediary.--Where a State enters into an agreement with the Government to pay the medical insurance premium on behalf of its aged welfare recipients, as explained in § 175, the agreement may provide for a designated State agency to serve as an intermediary on behalf of its welfare recipients.

120. ROLE OF PART A INTERMEDIARIES

The Part A intermediary is a public or private agency or organization that has entered into an agreement with the Social Security Administration to process Medicare claims under both Part A and Part B of providers of services, i.e., hospitals, skilled nursing facilities, home health agencies, outpatient physical therapy and speech pathology providers, and end-stage renal disease facilities. (Providers may elect to deal directly with the Social Security Administration.)

Intermediaries make payments to providers; the amount of reimbursement to any provider is restricted to the lesser of (a) the reasonable cost of covered services and items or (b) the customary charges with respect to such services. (See Provider Reimbursement Manual, §§ 2600ff.) In addition, intermediaries assist in the application of safeguards against unnecessary use of covered services, furnish consultative services to assist in the establishment and maintenance of requisite fiscal data, serve as a center for communicating with providers, conduct audits of provider records, assist in the beneficiary appeals process, and provide information and advice to institutions and organizations that wish to qualify as providers of services.

125. ROLE OF THE PART B CARRIERS

The law requires the Secretary to enter into contracts with carriers to serve as intermediaries in the operations and administration of the nonprovider Part B program. A principal function of these carriers is to determine whether charges of physicians (including facility-based physicians) and suppliers for covered Part B services constitute "reasonable charges" within the meaning of the law, and to make payment. Other major functions include, for example, controlling overutilization and communicating with the health community.

Provider Participation in Medicare

130. DEFINITION OF PROVIDER.

A. Providers of Services.-- A provider of services (or provider) is a hospital, skilled nursing facility, home health agency, and for the limitated purpose of furnishing outpatient physical therapy or speech pathology services, a clinic, rehabilitation agency, or public health agency which meets the applicable eligibility requirements of title XVIII of the Social Security Act and regulations issued there under (i.e., the conditions of participation).

B. Participating Providers.-- To be a participating provider, a provider must be in compliance with applicable provisions of title VI of the Civil Rights Act of 1964 (see §104) and must enter into an agreement under section 1866 of the Social Security Act which provides that it (1) will not charge any individual or other person for items and services covered by the health insurance program other than allowable charges and deductibles and coinsurance amounts, and (2) will return any money incorrectly collected from the individual or other person on his behalf or make such other disposition as described in §245.

A provider which has executed an agreement becomes qualified to participate after the agreement is accepted for filing. Where the agreement is made retroactive, the provider must comply with the terms of the agreement and the provisions of title XVIII and regulations issued there under as of the retroactive date. For payment to be made to the provider for covered items and services it furnishes on or after the effective date of the agreement, the provider must have a recordkeeping capability sufficient to determine the costs of services furnished to Medicare beneficiaries.

132. TERM OF AGREEMENT WITH HOME HEALTH AGENCIES (HHA's).

An agreement with a home health agency is not time-limited and has no fixed expiration date. The agreement remains in effect until such time as there is a voluntary termination, an involuntary termination, or an invalidation of the agreement by reason of change or ownership.

134. ADMISSION OF MEDICARE PATIENTS FOR CARE AND TREATMENT.

The participation of an HHA which voluntarily files an agreement to participate in the health insurance program contemplates that the HHA will give Medicare beneficiaries care and treatment and will provide them with such services as are ordinarily furnished by the HHA to its patients generally. An HHA may have restrictions on the types of services it makes available and the types of health conditions it accepts, or may establish other criteria relating to the start of care of persons for care and treatment. However, the law does not contemplate that such restrictions or criteria will apply only to Medicare beneficiaries as a class. It does contemplate, however, that if such restrictions apply to Medicare beneficiaries, they will be applied in the same manner in which they are applied to all other persons seeking care and treatment by the HHA. An HHA start of care or patient policy or practice which is not consistent with the objective contemplated in the law may be used by the Secretary as a basis for termination of the agreement for cause.

140. ELECTION OF INTERMEDIARY

A. Newly Participating Provider. --Except for freestanding home health agencies (HHA), freestanding hospices and providers that elect to deal directly with HCFA, providers may elect to be served by any intermediary already authorized to serve other providers of the same type in its area. Such elections are reviewed by the HCFA regional office. They will usually be approved unless special or temporary limitations have been placed on the elected intermediary's availability or it is determined that an addition to the elected intermediary's workload at the time would be undesirable. Where it is determined that an intermediary currently not available in an area could perform effectively in the area, and such a change in availability would be consistent with effective and efficient administration, the possibility of extending that intermediary's availability to the area will be considered.

For all freestanding HHAs and providers that elect to deal directly with HCFA, HCFA has designated the intermediaries available to serve those providers. Likewise, HCFA has designated the regional intermediaries that will service all freestanding hospices.

Direct questions regarding the availability of an intermediary to the HCFA regional office.

B. Provider Changing Ownership. --Providers which have undergone a change of ownership generally continue with the same intermediary that served the previous owner. However, where the new owner requests a different intermediary and the request is approved, the change of intermediary will be effective as follows:

1. If the provider ceased billing effective with the change of ownership, the effective date of the intermediary change is the effective date of the change of ownership. However, if the effective date of the provider's new certification to participate is determined to be later than the change of ownership, the effective date of the intermediary change is the new certification date.

2. If the provider continued billing after the change of ownership, the intermediary change is effective with the first day of the provider's fiscal year following its certification for participation in the program.

C. Provider Chains. —A highly centralized chain of providers may, because of the nature of its operations, require services through a single intermediary in order to improve administration. If a single intermediary would not be possible with the usual election procedures (e.g., the desired intermediary is not authorized to serve in some areas where chain facilities are located or is not authorized to serve the type of provider involved), the chain may nevertheless request special authorization for the intermediary to serve all its component facilities. Submit such requests to the HCFA regional office which has jurisdiction of the State in which the home office of the chain is located. The following factors, among others will be considered in determining whether such authorization will be granted:

Size.--The chain must comprise a minimum of 10 participating facilities or 500 certified beds. However, where the chain is confined to 3 contiguous States, it may be eligible if it comprises 5 facilities or 300 certified beds.

Central Controls.—The chain must demonstrate that effective central controls are exercised, assuring substantial uniformity in the operating procedures, utilization controls, personnel administration, and fiscal operations of the individual providers.

Intermediary Capacity.—Based on the chain's size and location of the individual facilities, the elected intermediary must be found to have the resources and capacity to effectively serve the chain.

NOTE: An intermediary would not become generally available to serve other providers in those areas where it has been approved to serve chain providers only.

D. Change of Intermediary.—If a participating provider wishes to change its intermediary, it must give notice to HCFA and to its intermediary at least 120 days prior to the end of the provider's current fiscal year. The request should be signed by an authorized representative of the provider and submitted with an explanation to the HCFA regional office for its area. Since changes of intermediary can be costly and disruptive to the program, HCFA determines, based on the reasons given and other pertinent factors, if a change of intermediary is warranted and would contribute to more effective and efficient program operations. Where HCFA approves of the change of intermediary, it becomes effective on the first day following the close of the fiscal year in which the provider gave timely notice.

E. Prohibition Against Intermediaries Soliciting Change of Intermediary.--Intermediaries are not permitted to solicit providers to request changes of intermediary. If you are solicited by an intermediary (e.g., an uninvited presentation or visit by an intermediary representative) for the purpose of persuading a change from the servicing intermediary, report the occurrence in writing to the HCFA regional office.

142. TERMINATION OF PROVIDER PARTICIPATION

A provider may voluntarily terminate its participation in the Medicare program or have it terminated for cause. The termination of participation does not immediately abrogate all of the provider's responsibilities and in specific matters a responsibility may extend beyond the effective date of termination. For example, the provider continues to be responsible (as applicable) for those provisions of the law which provide for Medicare coverage to remain in effect for 30 days following the effective termination date for those beneficiaries who were accepted for care and treatment by the provider before such date. The provider also continues to be responsible for filing a final cost report and/or the repayment of any overpayment, as these actions relate to final program cost settlement after termination.

The Secretary of DHHS may terminate from paticipation in the Medicare program any provider found guilty of program abuse. The Secretary is required to make the names of such organizations public so that beneficiaries will be informed about which providers cannot participate in the program. The situations for which termination will be made include overcharging, furnishing excessive, inferior, or harmful services, or making a false statement to obtain payment. Program review teams furnish professional advice to the Secretary in carrying out this authority. Any person or organization dissatisfied with the Secretary's decision to terminate will be entitled to a hearing by the Secretary and to judicial review of the Secretary's final decision.

142.1 Voluntary Termination by the HHA.-- An HHA may terminate its agreement by filing a written notice of its intention with the HCFA RO. HCFA may accept the termination date stated in the notice (the date must be the first day of a month) or set a different date. However, the termination date set by HCFA shall not be more than 6 months from the date the HHA's notice is filed.

The HHA will be advised as to the effective termination date of the agreement. It will also be advised of the need to give notice to the public at least 15 days in advance of the termination date. Information regarding the type of public notice which is to be given will be furnished to the HHA by the RO.

An agreement with an HHA which goes out of business (i.e., permanently or temporarily ceases to furnish services to the community) terminates effective with the date the HHA goes out of business. HHAs which contemplate going out of business should notify HCFA in advance so that proper notice can be given to the public.

142.2 Involuntary Termination by HCFA.-- HCFA may terminate an agreement with an HHA if it is determined that the HHA:

A. Is not complying substantially with the provisions of the agreement or with the applicable provisions of title XVIII of the Act and regulations; or

B. No longer meets the appropriate conditions of participation; or

C. Has failed to supply information which is necessary to determine whether payments are due or were due and the amounts of such payments; or

D. Refuses to permit examinations of fiscal and other records, including medical records; or

E. Has knowingly and willfully made or caused to be made false statements or representations with respect to facts material to the right to payment; or has submitted or caused to be submitted requests for payment for amounts substantially in excess of the costs incurred; or has furnished items or services which are substantially in excess of the individual's needs, are harmful, or are of a grossly inferior quality.

HCFA shall give notice of termination to the HHA and to the public at least 15 days before the effective termination date. After HCFA terminates an agreement with an HHA, the HHA may not file another agreement to participate unless HCFA finds that the reason for termination of the prior agreement has been removed and that there is reasonable assurance that it will not recur.

An HHA which is dissatisfied with HCFA's determination terminating its agreement is entitled to request a hearing in accordance with the appeals procedures in Federal Regulations 42 CFR 405, Subpart O. There is no reconsideration available before the hearing.

142.3 Determining Payment for Services Furnished After Termination.--Effective with the date an HHA agreement is terminated, no payment will be made to the HHA under the agreement for:

A. Home health services furnished under a plan which is established on or after the termination date. (However, if the plan was established before the termination date, payment can be made for services furnished up to 30 days following the effective date of termination.)

B. Other items and services, including outpatient physical therapy or speech pathology and diagnostic services, furnished on or after the date of termination.

Terminated agencies must continue to submit bills for Medicare reimbursement for covered home health services furnished after termination as indicated in A above. No-payment death or discharge bills should be submitted, as appropriate, for the period after termination per § 430.

145. CHANGE OF PROVIDER OWNERSHIP

When an organization having a provider agreement undergoes a change of ownership, the agreement is automatically assigned to the successor owner. A participating provider which plans to change ownership should give HCFA advance notice of its intention.

A participating provider which plans to enter into a lease arrangement (in whole, or in part) should also give advance notice of its intention. A change of ownership would occur for example:

A. Where a sole proprietor transfers title to the enterprise to another party;

B. Where, in the case of a partnership, the addition, removal, or substitution of a partner effects a termination of such partnership and creates a successor partnership or other entity;

C. Where an incorporated provider merges with an incorporated institution which is not participating in the program and the nonparticipating institution is the surviving corporation or where two or more corporate providers consolidate and such consolidation results in the creation of a new corporate entity;

D. Where an unincorporated provider (a sole proprietorship or partnership) becomes incorporated.

146. INSTITUTIONAL PLANNING AND BUDGET

As a condition of participation under Medicare, a HHA must have a written overall plan and budget reflecting an annual operating budget and a capital expenditures plan (that covers at least a 3-year period including the year to which the operating budget is applicable). The annual operating budget includes all anticipated income and expenses related to items which would under generally accepted accounting principles be considered income and expense items. The capital expenditure plan would be expected to include and identify in detail the anticipated sources of finance for, and the objectives of, each anticipated expenditure in excess of $100,000 related to acquisition of land, the improvement of land, buildings, and equipment, and the replacement, modernization, and expansion of the buildings and equipment which would, under generally accepted accounting principles, be considered capital items.

The overall budget and plan must be prepared under the direction of the provider's governing body by a committee consisting of representatives of the governing body, administrative staff and if any, the medical staff. Further, it must be reviewed and updated at least annually. The purpose of the requirement is to assure that providers carry on budgeting and planning on their own. Therefore, the plan will not be reviewed for substance by the Government or any of its agents.

Hospital Insurance

155. HOSPITAL INSURANCE—A BRIEF DESCRIPTION

This is the basic part of the health insurance program. It is designed to help patients defray the expenses incurred by hospitalization and related care. In addition to inpatient hospital benefits, hospital insurance covers posthospital extended care in skilled nursing facilities and posthospital care furnished by a home health agency in the patient's home. In providing these additional benefits, recognition was given to the need for continued treatment after hospitalization and the need to encourage the appropriate use of more economical alternatives to inpatient hospital care. Program payment for services rendered to beneficiaries by providers (i.e., hospitals, skilled nursing facilities, and home health agencies) are generally made to the provider based on the reasonable cost of the covered services furnished.

155.1 Posthospital Home Health Services.—Home health services are provided under hospital insurance and also under supplementary medical insurance. (For a complete discussion of these services, see Chapter II.)

155.2 Inpatient Hospital Services.—The items and services covered include: bed and board; nursing and other related services; use of hospital facilities and medical social services ordinarily furnished by the hospital for the care and treatment of inpatients; drugs, biologicals, supplies, appliances, and equipment for use in the hospital, which are ordinarily furnished by the hospital; diagnostic or other therapeutic items or services furnished by the hospital or by others under arrangements made by the hospital; services by interns or residents-in-training under approved teaching programs; and costs of blood after the first 3 pints in a benefit period and all costs of administering the blood including the provider's costs of administering the first 3 pints.

The patient is entitled to payment on his behalf for up to 90 days of inpatient hospital services in each benefit period. He is responsible for a deductible amount in each benefit period and a coinsurance amount equal to one-fourth of the inpatient hospital deductible for each day after the 60th day and through the 90th day of inpatient hospital services during a benefit period. In addition, a beneficiary has a 60-day lifetime reserve available for inpatient hospital services. Unless he elects not to use this reserve, he will be responsible for a coinsurance amount for each day used to equal to one—half of the inpatient hospital deductible for the benefit period in which such reserve days are used.

Inpatient tuberculosis hospital services are covered if the services furnished to the individual are services which can reasonably be expected to improve his condition or render it noncommunicable. Inpatient psychiatric hospital services are covered if the services furnished to the patient are furnished when he is receiving intensive treatment, or are necessary for medically-required inpatient diagnostic study. Where an individual is in a qualified psychiatric hospital on the first day for which he is entitled to hospital insurance benefits, the days on which he was an inpatient of such a hospital in the 150-day period immediately before his first day of entitlement must be counted in determining the 150-day limit on inpatient hospital services in his first benefit period. In addition, there is a lifetime limitation of 190 covered inpatient psychiatric hospital days in a psychiatric hospital. A period spent in a psychiatric hospital prior to entitlement, however, does not count against the 190 days.

Payment may be made for emergency inpatient hospital services furnished by nonparticipating U.S. hospitals when the threat to the life or health of the individual necessitates the use of the most accessible hospital. Payment may also be made for emergency inpatient hospital and certain related Part B services in Canada and Mexico where the foreign hospital is more accessible from the site of the emergency than the nearest participating U.S. hospital.

Inpatient hospital services and related Part B services provided to a United States resident in a hospital in Canada or Mexico which is closer or more accessible to his U.S. residence than the nearest participating U.S. hospital may be covered whether or not an emergency existed.

155.3 Posthospital Extended Care Services.--In each benefit period (as defined in § 157.3), payment may be made for the reasonable cost of up to 100 days of posthospital extended care services, except that the patient is responsible for a coinsurance payment equal to one-eighth of the inpatient hospital deductible for each day after the 20th day. The beneficiary must have been a hospital inpatient for at least 3 consecutive days (counting the day of admission but not the day of discharge) and be admitted to the skilled nursing facility (SNF) within 14 days after the date of hospital discharge (under certain circumstances, the 14 days may be extended).

An SNF provides skilled nursing care and related services for patients who require medical or nursing care; or rehabilitation services for injured, disabled, or sick persons. It may be either a separate institution (e.g., a nursing home) or a part of an institution (e.g., a convalescent wing of a hospital). It must be licensed or approved under State or local law, meet the health and safety conditions prescribed by the Secretary of Health, Education, and Welfare, and have a written transfer agreement with one or more participating hospitals providing for the transfer of patients between the hospital and the facility, and for the interchange of medical and other information. If an otherwise qualified SNF has attempted in good faith but without success to enter into a transfer agreement, this requirement may be waived by the State agency described in § 112.

The term skilled nursing facility does not include any institution which is primarily for the care and treatment of mental diseases or tuberculosis for Medicare purposes. However, the restriction does not include title XIX (Medicaid).

Extended care services include room and board; skilled nursing care by or under the supervision of a registered nurse; physical, occupational, or speech therapy; medical social services; and other services ordinarily furnished by the facility. No payment may be made for custodial care or for items or services which would not be covered in a hospital.

The services of residents and interns of a hospital with which the facility has a transfer agreement and other diagnostic and therapeutic services furnished by such a hospital are covered, but only if billed through the SNF.

157. HOSPITAL INSURANCE DEFINITIONS RELATING TO PART A HOME HEALTH SERVICES

157.1 Hospital.--A hospital (other than tuberculosis or psychiatric) is an institution which:

A. is primarily engaged in providing, by or under the supervision of physicians, to inpatients--

1. diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or

2. rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

B. maintains clinical records on all patients;

C. has bylaws in effect concerning its staff of physicians;

D. has a requirement that every patient must be under the care of a physician;

E. provides 24-hour nursing service by or supervised by a registered professional nurse and has a licensed practical nurse or registered professional nurse on duty at all times;

F. has in effect a hospital utilization review plan;

G. is licensed or is approved by the State or local licensing agency as meeting the standards established for such licensing;

H. meets other health and safety requirements of the Secretary of the Department of Health, Education, and Welfare. (These additional requirements may not be higher than comparable ones prescribed for accreditation by the Joint Commission on Accreditation of Hospitals with certain exceptions specified in the law.)

I. is not primarily for the care and treatment of mental diseases and tuberculosis.

(The special requirements to meet the definition of psychiatric hospital or tuberculosis hospital are outlined in the "Conditions of Participation for Hospitals," HIRM-1.)

157.2 Skilled Nursing Facility.--A skilled nursing facility (SNF) is one which provides skilled nursing care and related services for patients who require medical or nursing care; or rehabilitation services for injured, disabled, or sick persons. It may be either a separate institution (such as a nursing home) or a part of an institution (such as a convalescent wing of a hospital), licensed or approved for licensing under State or local law, and meets the health and safety conditions prescribed by the Secretary of the Department of Health, Education, and Welfare. The SNF must have a written transfer agreement with one or more participating hospitals providing for the transfer of patients between the hospital and the facility and for the interchange of medical and other information. If an otherwise qualified facility has attempted in good faith, but without success, to enter into such an agreement, the agreement requirement may be waived by the State agency. A facility primarily for the care and treatment of mental disease or tuberculosis may not qualify as a participating SNF in the health insurance program.

A patient can meet the prior stay requirement for "posthospital" home health services furnished prior to July 1, 1981 (see Chapter II) by a covered stay in a participating SNF. See § 155.3 for the conditions of a covered stay.

157.3 Benefit Period Defined.--A benefit period is a period of consecutive days that begins with the first day (not included in a previous benefit period) on which a patient is furnished inpatient hospital or extended care services by a qualified provider in a month for which the patient is entitled to hospital insurance benefits. (The term "benefit period" is synonymous with "spell of illness.") A qualified hospital (including a psychiatric or tuberculosis hospital) or SNF is one that meets all the requirements of the definition of such an institution. A hospital which meets the requirements described in § 157.1E and G is also a qualified hospital for purposes of beginning a benefit period when such hospital furnishes the patient covered inpatient emergency services. In addition, for purposes of qualifying for posthospital home health benefits, a benefit period begins with a stay in a hospital accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association even though the hospital does not participate in the Medicare program. Effective July 1, 1981, the prior inpatient stay requirement under Part A was eliminated. Generally, the benefit period begins when covered inpatient services are initially furnished to an entitled individual.

See § 210.1 for the benefit period as it relates to entitlement to posthospital home health benefits for services furnished prior to July 1, 1981.

The benefit period ends with the close of a period of 60 consecutive days during which the patient was neither an inpatient of a hospital nor an inpatient of an SNF. In determining the 60-consecutive-day period, begin counting with the day the individual was discharged. It is important to note that for purposes of continuing a benefit period, the hospital or SNF in which the stay occurs need not meet all the requirements that are necessary for starting a benefit period. Inpatient services will prolong the beneficiary's benefit period if the hospital is primarily engaged in providing, by or under the supervision of physician(s), to inpatients (1) diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for injured, disabled, or sick persons; or (2) psychiatric services for the diagnosis and treatment of mentally ill persons; or (3) medical services for the diagnosis and treatment of tuberculosis.

Similarly, inpatient services in an SNF will prolong a beneficiary's benefit period if the facility (including one primarily for the care and treatment of mental diseases or tuberculosis) meets at least the requirement that it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for injured, disabled, or sick persons.

An individual may be discharged from and readmitted to a hospital or SNF several times during a benefit period and still be in the same benefit period if 60 days have not elapsed between discharge and readmission. The stay need not be for related physical or mental conditions.

As long as a person continues to be entitled to hospital insurance, there is no limit to the number of benefit periods he may have.

EXAMPLE 1: X was born August 9, 1902. On July 28, 1967, X entered a participating general hospital. After he had been in the hospital for 2 weeks, X was discharged on August 11, 1967. On his doctor's orders, X entered a participating nursing home on August 15, 1967, and remained there until his discharge on October 27, 1967. He had no further inpatient stays in 1967.

X's benefit period began on August 1, 1967, the first day of the month he attained age 65 and was entitled to hospital insurance. The benefit period ended December 25, 1967, the end of the 60-day period beginning with the day of the last discharge.

EXAMPLE 2: Y, over age 65, entered a participating general hospital on July 28, 1968, for treatment of a heart condition. He was discharged on August 11, 1968. On August 20, 1968, Y entered a nonparticipating nursing home, which provided primarily skilled nursing care and related services. Y remained in this facility until his discharge on October 27, 1968. On December 25, 1968, Y was again admitted to a participating hospital because of injuries suffered in an accident. He was discharged on January 13, 1969, and had no further inpatient stays in 1969.

Y's benefit period began on July 28, 1968. His stay in the nursing home began less than 60 days after his hospital discharge and the spell was continued even though the stay was not covered. The subsequent hospital stay began less than 60 days after the nursing home discharge and continued the benefit period although the condition treated was unrelated to his prior stays. The benefit period ended on March 13, 1969, the end of the 60-day period beginning with the day of last discharge.

Supplementary Medical Insurance

160. SUPPLEMENTARY MEDICAL INSURANCE—A BRIEF DESCRIPTION

160.1 Benefits.—The voluntary medical insurance plan is designed to supplement the basic hospital insurance coverage. It provides coverage for home health visits and medical and other health services.

A. Supplementary Medical insurance covers unlimited home health services but see §160.5(B)(2) for exception.

B. Medical and other health services include:

1. Physicians' services (see definition of "physician" below) including surgery, consultation, and home, office, and institutional calls.

Regardless of the actual expenses for physician services incurred in the treatment of mental, psychoneurotic, or personality disorders of persons who are not inpatients of hospitals, the amount of such expenses that can be counted in a calendar year is limited to the lesser of $312.50 or 62.5 percent of the actual expenses.

Physician means a doctor of medicine, osteopathy (including osteopathic pracitioner) or podiatric medicine, legally authorized to practice by a State in which he performs the function. A doctor of dental surgery or dental medicine having State authorization to practice is also defined as a physician but only for surgery related to the jaw or any structure contiguous to the jaw, or the reduction of a fracture of the jaw or any facial bone. In general, "the jaw or any structure contiguous to the jaw" includes structures of the facial area below the eyes, e.g., mandible, teeth, gums, tongue, palate, salivary glands, sinuses, etc. With respect to certain specified treatment, a physician is a doctor of chiropractic legally authorized to practice by a State in which he performs this function. The services performed by physicians within these definitions are subject to any limitations imposed by the State on the scope of practice.

"Physicians' services" also includes services performed by podiatrists within the scope of applicable State licenses. This allows payment for certain foot care services whether furnished by a doctor of medicine, osteopathy, or podiatric medicine (to the extent that each is legally authorized to perform the services). Certain foot care services (including routine care), however, are excluded regardless of who performs them. (See S 232.9.)

A doctor of podiatric medicine is a "physician" for the purpose of making the required physician certifications and recertifications of the medical necessity for Part A and Part B services if the performance of these functions by a doctor of podiatric medicine is: (1) consistent with the policies of the institution or agency with respect to which these functions are performed and (2) consistent with the scope of the professional services provided by a doctor of podiatric medicine as authorized under applicable State law (S 240ff.). A podiatrist is not a "physician" for the purpose of any of the physician activities required to qualify an organization as a home health agency (SS200ff. and 203).

Thus, a podiatrist may not be a "physician" member of the group of professional personnel responsible for establishing policies governing the services provided by the home health agency, nor may a podiatrist furnish any of the "physician" supervision of the agency's services required by the statute or Conditions of Participation for Home Health Agencies. A podiatrist is a "physician" for the purpose of establishing or reviewing a home health plan and satisfies the requirement that each home health patient must be under the care of a "physician." However, the performance of these functions by a doctor of podiatric medicine must be: (1) consistent with the policies of the institution or agency with respect to which he/she performed them and (2) consistent with the scope of professional services provided by a doctor of podiatric medicine under applicable State law.

For prosthetic lenses furnished on or after October 30, 1972, a doctor of optometry, legally authorized to practice optometry by the State in which he performs such functions, is a "physician" as defined in the law, but only for the purpose of attesting to the patient's need for prosthetic lenses. Thus, payment may be made for necessary prosthetic lenses (see 8 below) whether prescribed by an optometrist or other physician authorized to do so.

2. Services and supplies as follows:

a. Services and supplies (including drugs and biologicals which cannot be self-administered) incident to physicians' professional services and of kinds commonly furnished by a physician in his office and which are commonly rendered without charge or included in his bill.

b. Hospital services (including drugs and biologicals which cannot be self-administered) incident to physicians' services rendered to outpatients.

c. Diagnostic services which are (1) furnished on an outpatient basis by the hospital or others furnishing the services under arrangements, and (2) ordinarily furnished by the hospital (or others under arrangements to outpatients for diagnostic study). (See § 219ff.)

3. Diagnostic X-ray, laboratory, and other diagnostic tests.

4. X-ray, radium, and radioactive isotope therapy, including material and services of technicians.

5. Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations.

6. Rental or purchase of durable medical equipment (iron lungs, oxygen tents, wheelchairs, special beds) for use in the patient's home or place considered to be his residence.

7. Ambulance service, where the use of other transportation is contraindicated by the patient's condition.

8. Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices.

9. Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition.

10. Outpatient physical therapy and outpatient speech pathology services furnished by or under arrangements made by participating providers of services (including clinics, rehabilitation agencies, and public health agencies). This includes those Part B services furnished by hospitals to their inpatients who have exhausted their Part A inpatient benefits or who are otherwise not eligible for Part A benefits. Effective with services furnished on or after July 1, 1973, coverage of outpatient physical therapy was also expanded to include the services of a qualified physical therapist in independent practice when furnished in his office or the beneficiary's home; expenses incurred for such services in a calendar year may not exceed $100 for services rendered prior to 1982 and $500 for services rendered on or after January 1, 1982. (See § 219ff. for home health agency services which may be covered as medical and other health services.)

11. Pneumococcal pneumonia vaccine and its administration; hepatitis B vaccine and its administration (See § 219), and blood clotting factors for hemophiliac patients and their administration.

12. Certain medical supplies used in connection with home dialysis delivery systems;

13. ESRD composite rate for all outpatient maintenance dialysis items and services;

14. Antigens prepared by a physician;

15. Rural health clinic services;

16. Comprehensive outpatient rehabilitative services;

17. Ambulatory surgical facility services furnished in connection with certain surgical procedures;

18. Services furnished in a health maintenance organization by a clinical psychologist, a physician assistant, or nurse practitioner, and services and supplies furnished incident to such services.

Payment may not be made under Part B for services furnished an individual if he is entitled to have payment made for those services under Part A. An individual is considered entitled to have payment made under Part A if the expenses incurred were used to satisfy a Part A deductible or coinsurance amount, or if payment would be made under Part A except for the lack of request for payment or physician certification.

160.2 Basis for Payment.—Payment for services covered by medical insurance and rendered by a participating hospital, skilled nursing facility, home health agency, or other provider of services, or under arrangements made by such providers, is based on the reasonable cost of the services and is usually made to the provider of services.

Payment based on reasonable charges may be made to or on behalf of individuals covered by medical insurance for services of physicians and other medical and health services furnished under the program. In determining the reasonableness of charges, the carrier takes into consideration the customary charges of the physician (or other person rendering the service) as well as the prevailing charges in the locality generally made for similar services. A charge is not reasonable if it is higher than the charge applicable for a comparable service and under comparable circumstances to the carrier's own policyholders or subscribers.

160.3 ANNUAL PART B DEDUCTIBLE AND COINSURANCE

In each calendar year, a cash deductible must be satisfied before payment can be made under the supplementary medical insurance plan. (See §160.5 for exceptions.)

As of January 1, 1982, the deductible is $75.

From 1973 through 1981, the deductible was $60.

From 1966 through 1972, the deductible was $50.

Expenses count toward the deductible on the basis of incurred, rather than paid expenses, and are based on the reasonable charge. Noncovered expenses do not count toward the deductible. Even though an individual is not entitled to Part B benefits for the entire calendar year, i.e., his insurance coverage begins after the first month of a year or he dies before the last month of the year, he is still subject to the full deductible for that year. Medical expenses incurred in the portion of the year preceding entitlement to medical insurance are not credited toward the deductible.

The date of service generally determines when expenses were incurred, but expenses are allocated to the deductible in the order in which the bills are received by the intermediary. Services which are not subject to the deductible cannot be used to satisfy the deductible.

After the deductible has been satisfied, providers will generally be paid the lesser of the reasonable costs or customary charges less 20 percent of the reasonable charge but no more than 80 percent of the reasonable costs, and physicians and other suppliers 80 percent of the reasonable charges, incurred during the balance of the calendar year. The patient is responsible for a coinsurance amount equal to 20 percent of the reasonable charges for the items and services. (See §160.6 for exceptions.)

160.4 Special Carryover Rule for Expenses Incurred Prior to 1981.--Expenses incurred in the last 3 months of a calendar year prior to 1981, which were applied toward the Part B deductible for that year, may also be credited towards the deductible for the following year.

NOTE: This deductible carryover provision was repealed effective with expenses incurred on or after October 1, 1981.

160.6 Exceptions to Part B Deductible and Coinsurance.--

A. The 20 percent coinsurance does not have to be met with respect to the following:

1. Purchased or rented used durable medical equipment (DME) including DME furnished as a home health benefit, if the charge does not exceed 75 percent of the reasonable charge of new equipment.

2. Preadmission Diagnostic Testing services furnished from December 5, 1980 through July 18, 1984.

B. Neither the annual deductible nor the 20 percent coinsurance apply with respect to:

1. Radiology and pathology services furnished before October 1, 1982 to inpatients of qualified hospitals by physicians in the fields of radiology or pathology. (Services furnished on or after July 1, 1981, were exempt from the deductible and coinsurance only if the physician agreed to accept assignment for all radiology or pathology physician services furnished to hospital inpatients);

2. Part B home health services, except that there is a coinsurance of 20 percent of the reasonable charge for durable medical equipment furnished as a home health benefit on or after July 18, 1984. (See IM 414.)

3. Clinical diagnostic laboratory tests (including specimen collection fees) performed or supervised on or after July 1, 1984, by a physician, laboratory, or other entity reimbursed on an assigned basis,

4. Certain surgical procedures performed by a physician in an ambulatory surgical center or outpatient department of a hospital.

5. Ambulatory surgical facility services in ambulatory surgical center.

6. Pneumococcal vaccine and its administration furnished on or after July 1, 1981.

NOTE: Services which are not subject to the deductible cannot be used to satisfy the deductible.

Beneficiary Entitlement to Hospital Insurance Benefits

Sections 165 through 185 provide background information on entitlement. The social security office should be contacted if there is any question concerning an individual's entitlement under Part A or Part B.

165. HOSPITAL INSURANCE ENTITLEMENT FOR THE AGED (PART A)

An individual is entitled to hospital insurance (HI) protection beginning with the first day of the month in which he is age 65 or over and is entitled to monthly social security benefits (to be distinguished from supplementary security payments). Such entitlement also extends to aged qualified railroad retirement beneficiaries.

Hospital insurance coverage ends with the month the individual ceases to be entitled to such monthly social security benefits and/or ceases to be a qualified railroad retirement beneficiary. In the rare cases where HI terminates for an aged individual because of termination of his monthly benefits, he may obtain premium HI (described in § 168) by filing a timely application. Death also terminates HI; the HI coverage continues through the date of death.

165.1 Transitional Provision for the Uninsured.—Special provision was made to blanket in many older people who did not have social security insured status at the time Medicare began in 1966. Thus, aged people not entitled to HI by reason of being monthly beneficiaries could be entitled if certain prescribed requirements were met. Practically all persons eligible under this provision have already been awarded HI by this time; people attaining age 65 after 1974 must be entitled to monthly benefits in order to have premium-free HI.

166. HOSPITAL INSURANCE FOR DISABILITY BENEFICIARIES

Effective July 1, 1973, beneficiaries under age 65 who have been entitled to disability benefits under either the Social Security or Railroad Retirement Act for at least 25 consecutive months are entitled to HI beginning with the 25th month of entitlement and are automatically enrolled in the supplementary medical insurance (SMI) program.

HI and SMI coverage for beneficiaries under age 65 who qualify under this provision terminates the month the disability benefit terminates or the month following the month in which notice of termination of disability benefits is mailed to the beneficiary, whichever is later.

There are three types of disability beneficiaries who can qualify for Medicare under this provision: disabled workers who have the necessary insured status; disabled widows and widowers of workers who were insured at death; and disabled adult children (age 20 or older) of deceased insured workers or workers entitled to monthly benefits.

167. HOSPITAL INSURANCE FOR PERSONS NEEDING KIDNEY TRANSPLANT OR DIALYSIS

A. Effective October 1, 1978.—Individuals of any age who receive dialysis or renal transplantation for end-stage renal disease (ESRD) are eligible for HI (and are deemed enrolled for SMI unless such coverage is refused) if they file an application and they: (1) meet certain work requirements for insured status under the social security or railroad retirement programs, or (2) are entitled to monthly social security benefits or an annuity under the Railroad Retirement Act, or (3) are the spouses or dependent children of such insured or entitled persons.

HI entitlement usually begins after a 3-month waiting period has been served, i.e., with the first day of the third month after the month in which a course of renal dialysis begins. Entitlement begins before the waiting period has expired if the individual (1) receives a transplant or (2) participates in a self-dialysis training program during the waiting period. For those falling into category (1), entitlement begins with the month the individual is admitted as an inpatient to a hospital for procedures in preparation for or anticipation of a kidney transplant provided the transplant surgery takes place within the following 2 months. If the transplant is delayed more than 2 months after the preparatory hospitalization, entitlement begins with the 2nd month prior to the month of transplant. Entitlement for those falling into category (2) begins with the first month of the course of dialysis if the individual is expected to complete the self-dialysis training program and self-dialyze thereafter. Eligibility is based on the earliest entitlement date when someone could possible qualify under several different provisions.

HI coverage based on end-stage renal disease ends with the earliest of the following dates: (1) the day an individual dies, or (2) the last day of the 12th month after the month the course of dialysis is discontinued, unless the individual receives a kidney transplant during that period or begins another course of dialysis, or (3) the last day of the 36th month after a person receives a kidney transplant. If the transplant fails and a regular course of dialysis is initiated or another transplant is performed within the 36 months, entitlement continues. If a person whose entitlement based on ESRD has ended begins a new course of dialysis or has a kidney transplant, reentitlement begins without a waiting period.

B. Prior to October 1, 1978.--For the period July 1, 1973 (the effective date of the original ESRD provisions) through September 30, 1978, an individual had to be under age 65 to qualify as an ESRD beneficiary, and the filing of an application was not a condition of entitlement.

HI entitlement began with the third month after the month in which a course of renal dialysis began except for the individual who received an early transplant. Entitlement for transplant patients began with the month in which the surgery was performed or in the previous month if the patient was hospitalized in that month in anticipation of and in preparation for such transplant surgery.

HI terminated as in Section A. above except that termination for a transplant patient took place on the last day of the 12th month after the month in which the patient received the transplant. A new waiting period had to be served by persons seeking reentitlement on the basis of ESRD.

168. HOSPITAL INSURANCE OBTAINED BY PREMIUM PAYMENT

168.1 Eligibility Requirements.--An individual age 65 or over who wants HI but is not insured for monthly benefits, and does not meet the ESRD requirements (§ 167), may enroll for such coverage, for which he must pay a substantial monthly premium, if he meets certain requirements relating to citizenship or residence (see § 175A(2)) and enrolls in SMI. Entitlement ends if: premiums are not paid within the grace period; SMI terminates; entitlement to nonpremium HI is established; the beneficiary voluntarily terminates his HI; or the beneficiary dies. The amount of the premium is determined each year based on the cost of services covered by HI.

Entitlement to Supplementary Medical Insurance Benefits

175. SUPPLEMENTARY MEDICAL INSURANCE ENTITLEMENT (PART B)

A. Eligibility for Enrollment.--To obtain SMI, an eligible individual must enroll during an enrollment period open to him, and pay the required premiums. He is eligible to enroll if he either (1) is entitled to premium-free HI; or (2) is 65 years old and is a resident citizen or an alien who meets certain residence requirements.

Payment may be made for covered services if the individual had coverage at the time the services were furnished, even though at the time the request for payment is filed with the intermediary his enrollment has terminated.

B. Automatic Enrollment in SMI for Individuals Entitled to Hospital Insurance After June 1973.--Eligible individuals (except those residing in foreign countries or Puerto Rico) who first become entitled to HI on or after July 1, 1973, are deemed enrolled for supplementary medical insurance (SMI) as follows:

An individual under 65 who becomes entitled to HI has SMI beginning with the first month of HI entitlement.

A beneficiary who is already on the monthly benefit rolls when he attains age 65 has HI and SMI effective with the month he attains age 65.

For an insured person filing for monthly benefits within 3 months before or after the month he attains age 65 (i.e., within his initial enrollment period (IEP)) SMI coverage begins at 65 or within 6 months thereafter, depending upon when he filed the application establishing his HI entitlement. If the application establishing his entitlement to HI is filed more than 3 months after age 65 and outside any GEP (defined in C2 below), he will be deemed to have enrolled in the next GEP and his coverage will begin on July 1 after the GEP.

Every person subject to automatic enrollment is given a reasonable opportunity to decline SMI by filing timely notice with SSA.

C. Enrollment Periods.--Enrollment for those not subject to automatic enrollment or who refuse automatic enrollment is possible only during certain enrollment periods:

1. An individual's initial enrollment period is of 7 months duration. It begins 3 months before and ends 3 months after the month he meets all eligibility requirements.

2. A general enrollment period (GEP) occurs each year from January 1 through March 31. A person enrolling in a GEP has coverage effective the following July 1.

The GEP's afford enrollment opportunities to those who failed to enroll during the initial enrollment period and to those whose enrollment has terminated. However, a person cannot enroll for SMI more than twice.

D. State "Buy-In".—A State which has entered into a buy-in agreement with SSA may enroll indigent persons eligible for SMI. The State may enroll such persons at any time after they qualify for buy-in regardless of enrollment periods. The State pays the SMI premiums for the persons it enrolls.

180. WHEN COVERAGE ENDS

SMI coverage terminates if any of the following events occurs: the premiums are not paid within the grace period; the enrollee voluntarily withdraws from SMI; HI terminates for the enrollee who is under age 65; the enrollee dies. SMI also may terminate when a buy-in enrollee is no longer eligible for buy-in (e.g., his income increases substantially); however, the enrollee has the option of keeping SMI and paying the premiums himself.

185. EQUITABLE RELIEF TO CORRECT RESULTS OF GOVERNMENT ERROR, MISREPRESENTATION, OR INACTION IN SMI ENTITLEMENT

SSA is authorized to take corrective action as necessary to provide relief where an individual's SMI enrollment rights have been prejudiced as a result of error, fault, or delay by an employee or agent of the Government. Such relief may include, but is not limited to, the designation of special enrollment or coverage periods with appropriate adjustment of premium liability.

For purposes of this provision, an individual's SMI enrollment rights will be deemed to have been prejudiced by Government fault wherever there is evidence showing that (a) the individual took reasonably appropriate and timely measures to assert his rights and (b) due to an administrative fault his rights would be impaired unless relief is given.

Disclosure of Information

190. DISCLOSURE OF HEALTH INSURANCE INFORMATION—GENERAL

Records and information acquired in the administration of the Social Security Act may be disclosed only under the conditions prescribed in rules and regulations or on the express authorization of the Commissioner of Social Security. Regulations of the Social Security Administration regarding the disclosure of records and information apply to governmental and private agencies participating in the administration of the program; to institutions, facilities, agencies, and persons providing services; and to those furnishing services under arrangements with a provider of services.

Information furnished specifically for purposes of a claim under the health insurance program is subject to these rules and regulations. Such information includes the individual's health insurance claim number, facts regarding his entitlement to health insurance benefits, and medical and other information obtained from the Social Security Administration or an intermediary.

However, the information in the HHA's own records of a patient (e.g., name, date of birth, sex, marital status, address, medical records) is not subject to these rules and regulations even though the patient receives benefits under the health insurance program. These records are subject to the requirements of confidentiality in the "Conditions of Participation for Home Health Agencies," and may also be subject to State or local laws or home health agency rules governing disclosure.

When an HHA receives a request for information about a Medicare beneficiary, a Medicare claim, or related information which it may not disclose, the inquirer should be referred to the appropriate intermediary for further consideration of his request.

191. DISCLOSURE OF HEALTH INSURANCE INFORMATION TO A BENEFICIARY, OR IN CONNECTION WITH A CLAIM

191.1 Disclosure to the Beneficiary or His Authorized Representative.—

A. General.—Information directly relating to the beneficiary, such as Medicare entitlement or eligibility data, may be disclosed to the individual or his authorized representative (including his representative payee).

B. Medical Information.—HHA's may not forward medical information to intermediaries on a confidential basis, expressed or implied, since under the Privacy Act any medical information obtained by an intermediary is subject to disclosure to the individual to whom it pertains, or to another person authorized by the individual to have access to it.

Some HHA's document findings on medical forms preprinted "confidential," or routinely stamp all records "confidential," whether or not such records are ever intended for disclosure to an intermediary. Such records, when transmitted to the intermediary, will be accepted only if accompanied by a signed statement that the HHA understands the information is subject to disclosure to the patient under the Privacy Act and any words or statements that the transmitted records are confidential may be disregarded if the patient or his representative requests them from the intermediary or from HCFA. The repeated preparation and forwarding of separate signed statements can be obviated if the HHA signs an appropriate general statement of understanding with the intermediary that medical information may be disclosed to the individual under the Privacy Act, even if it is routinely designated "confidential."

191.2 Disclosure to Third Parties for Proper Administration of the Health Insurance Program.--Disclosure of any record, report, or other information about an individual is authorized without the consent of the individual in connection with any claim or other proceeding under the Social Security Act only when disclosure is necessary for the proper performance of the duties of:

A. Any officer or employee of the Department; or

B. Any officer or employee of a State agency, intermediary, provider of services, or other agency or organization participating in the administration of the program by contract or agreement in carrying out such contract or agreement.

These limitations apply whether or not the individual to whom the information pertains authorizes further disclosure to third parties (e.g., to a private medical plan).

191.3 Disclosure to Third Parties for Other Than Program Purposes.--Information obtained from HCFA or its intermediary is confidential and may be disclosed only under conditions prescribed in rules and regulations, or on the express authorization of the Administrator of the Health Care Financing Administration. However, certain limited information about the Medicare eligibility status of beneficiaries and related claims information may be released to third party payers with the beneficiary's express authorization.

A. Information Which May Be Released.--Subject to necessary authorization, only the following records may be released:

1. beneficiary health insurance claim number;

2. coinsurance and deductible;

3. dates of entitlement to Medicare;

4. copies of Medicare claims forms;

5. Medicare report of eligibility;

6. Explanation of Medicare Benefits (EOMB);

Requests for other information desired for complementary insurance purposes should be referred to the intermediary.

B. Form of Authorization.--Make certain that information is not released without the required authorization. The authorization must:

1. be in writing;

2. be signed and dated by the individual or someone authorized to act in his behalf;

3. specify the name of the provider being authorized to disclose information;

4. specify what information the individual is authorizing the provider to disclose;

5. specify the names of the third party payers to whom the information is being released;

6. specify the purpose for which the information is being released; and

7. specify an expiration date for the authorization which should not exceed 2 years from the date it was signed and specify that it may be revoked at any time.

191.4 Disclosure for Payment of Claims in Alcohol and Drug Abuse Cases.--The law requires providers to observe more stringent rules when disclosing medical information for claims processing purposes from the records of alcohol and drug abuse patients than when disclosing information for other Medicare beneficiaries. Since the standard consent statement on the provider billing form is not sufficient authority under the law to permit the provider to release information from the records of alcohol or drug abuse patients, more explicit consent statements are required.

Providers participating in Medicare and alcohol and drug abuse prevention and treatment programs must obtain written consent from beneficiaries to release medical information in each alcohol or drug abuse case. This written consent, which will allow the provider to disclose the records of the patient, should include all of the following:

1. The name of the organization (hospital, etc.) which is to make the disclosure;

2. The name or title of the person or organization to which disclosure is to be made (e.g., the Health Care Financing Administration, including the appropriate intermediary or carrier, specified by name);

3. The name of the patient;

4. The purpose or need for disclosure (e.g., for processing a claim for Medicare payment and for such evaluation of the treatment program as is

legally and administratively required in the overall conduct of the Medicare program);

5. The specific extent or nature of information to be disclosed (e.g., all medical records regarding the beneficiary's treatment, hospitalization and/or outpatient care including treatment for drug abuse or alcoholism);

6. A statement that the beneficiary may revoke his consent at any time to prohibit disclosures on or after date of revocation;

7. A statement specifying a date (not to exceed 2 years), event, or condition upon which consent will expire without revocation;

8. The date on which the consent is signed;

9. The signature of the patient; or the signature of his authorized or legal representative.

If the beneficiary wishes, the consent statement may be expanded to permit disclosure by the provider to any other person, organization, or program, such as a PSRO, as appropriate. Authorization may also be given to HCFA and its contractors to redisclose specific information to third party payers for complementary insurance purposes. (See §191.3 above.)

The provider should keep the consent statement with the patient's medical and other records. The duration of the consent statement is not to exceed 2 years, after which it must be renewed by the beneficiary if further disclosures are necessary.

192. DISCLOSURE OF INFORMATION ABOUT HHAs BY HCFA

The following information about HHAs participating in the Medicare program may be disclosed by HCFA under the Freedom of Information Act in response to requests from the public.

192.1 Medicare Reports.--

A. Provider Survey Report and Related Information.--Information concerning survey reports of HHAs, as well as statements of deficiencies, based on survey reports completed after January 31, 1973, are available at the local social security office or the public assistance office in the area where the facility is located. The following data may be released under this provision:

1. The official Medicare report of a survey concluded on or after January 31, 1973;

2. Statements of deficiencies which have been conveyed to the HHA following a survey concluded on or after January 31, 1973;

3. Plans of correction and pertinent comments submitted by the provider relating to Medicare deficiencies cited following a survey concluded on or after January 31, 1973.

State agencies certify whether institutions or other entities meet the Medicare conditions of participation for HHAs. (See §112.) A State agency may disclose information it obtains relating to the qualifications and certification status of HHAs it surveys.

B. Program Validation Review Reports and Other Formal Evaluations.--Upon written request, official reports and other formal evaluations of the performance of HHAs completed after January 31, 1973, are made available to the public. After the survey reports and other formal evaluations are prepared by personnel of the Health Care Financing Administration, the evaluated HHA must be given an opportunity (not to exceed 30 days) to review the report and submit comments on the accuracy of the findings and conclusions. The HHA's comments must be incorporated in the report if pertinent.

Program validation review reports are generally released from the Medicare regional office serving the area in which the provider is located.

Generally, informal reports and other evaluations of the performance of HHAs which are prepared by the intermediary are available to the public.

C. HHA Cost Reports.--

1. General.--Requests by any member of the public either to inspect or to obtain a copy of an HHA cost report must be submitted to HCFA or the intermediary in writing and must identify the HHA and specific cost report(s) in question.

Intermediaries are required to respond to requests in writing within 10 working days after receipt of a written request, to advise the requester of the date the reports will be made available. That date will be no earlier than 10 working days from the date of the intermediary's response. However, no 10-day delay in furnishing cost reports is necessary when the request is from a Federal or State agency that needs cost report information to carry out the requirements of the Social Security Act or the request is from a member of Congress acting in his official capacity. Requests from individual members of the House or Senate are considered as requests from the public. A copy of the response to the requester will be sent simultaneously to the HHA, putting the HHA on notice that its report has been requested by a particular person. If a request is for a report submitted by a former owner of an HHA, copies of the intermediary's response to the requester will go to both the present owner and the former owner of the HHA. If the request is for a report submitted by a provider no longer participating in the Medicare program, a copy of the intermediary's response will be sent to the HHA. In the case of both a former owner and a former participating HHA, the copy of the response will be sent to the last known address of the party.

2. Information That May Be Disclosed.--Disclosure by the intermediary is limited to cost report documents which HHAs are required by HCFA regulations and instructions to submit and, in case of a settled cost report, the intermediary's notice of program reimbursement. These documents include the statistical page, the settlement pages, trial balance

of expenses, and cost finding schedules or documents required by SSA as part of the regular cost report process. (Where an HHA, after first obtaining program approval, has submitted equivalent documents in lieu of official program documents, these documents are subject to the same disclosure rules as official forms.)

If a request is received to inspect or to obtain a copy of a report that has not been settled, i.e., the final settlement notice of program reimbursement has not been sent, the intermediary will disclose a copy of the report as submitted by the HHA. If settlement has been made, the intermediary will disclose the settled report. If a requestor specifically asks for both the settled and unsettled cost reports of an HHA, the intermediary will comply with such request. When a report is made available for inspection or copying, it will be clearly marked with one of the following captions, as applicable:

a. Cost report as submitted

b. Settlement subject to audit

c. Audited settlement

When an intermediary discloses a settled report, schedules applicable to the settlement that have been reworked by the intermediary are disclosable. The general rule is that if the intermediary has reworked any of the schedules that were required to be submitted by the HHA with its original submission, these schedules become an integral part of the report for disclosure purposes. However, any details containing intermediary or auditor comments concerning the settlement, details of specific adjustments, or supporting schedules applicable to the settlement of the HHA's operation are not disclosed by the intermediary.

Information obtained in auditing HHA cost reports and other financial records may be released by SSA.

3. Information That May Not be Disclosed.—If an HHA chooses to submit with its cost report additional information not specifically required by regulations or instructions, the intermediary will not disclose such information unless it is contained within an official document. For example, some HHA's may submit supplementary analyses of certain expenses, details of the professional component adjustment, financial statements (other than the statement of income and expenses and the balance sheet as required in accordance with cost reporting instructions), or income tax returns, etc., that are not required by the program. These items would not be disclosed by the intermediary as part of the cost report.

Except where an HHA has not submitted an acceptable cost report and supplements are required to complete the report, any additional documents or schedules that the intermediary requires the HHA to submit in support of its cost representations would also not be disclosed by the intermediary as part of the cost report. In addition, the following are not disclosed by the intermediary as part of a cost report: audits, schedules, letters, notes, general comments; comments on results of desk reviews (including copies of the actual desk review documents), intermediary notices and comments (including transmittal letters), audit adjustment summaries that are required to be prepared by intermediaries and auditors, and information pertaining to an individual patient.

NOTE: Any of the information indicated above that is not to be disclosed by the intermediary may be subject to disclosure under the Freedom of Information Act upon review by the Health Insurance Regional Office, Central Office, or a U.S. District Court in response to a request for such information. The description of what will be made available by an intermediary as part of a cost report pertains only to requests that indicate that the requestor specifically wants cost reports.

192.2 Disclosure of Medicare Statistics.--Numerous statistics on individual HHA's are available to the public. They include, but are not limited to, the following:

1. Waiver of liability statistics

2. Interim rate payment data

3. Amount of Medicare reimbursement

4. Overpayment data

5. Data from the Provider Monitor Listing

6. Information from the Directory of Medical Facilities and the Directory of Medicare Providers and Suppliers of Services

7. Medicare statistics (e.g., total visits, number of starts of care).

192.3 Other Information That May be Disclosed.--

1. Presumptive waiver of liability status of the HHA;

2. Information as to whether an HHA participates in the Medicare program.

193. COST TO AN HHA WHICH REQUESTS INFORMATION AVAILABLE TO THE PUBLIC

HHA's are required to pay appropriate fees for information they may request pertaining to other providers, Medicare contractors, or State agencies. An HHA may claim such fees as allowable costs only if it demonstrates to the intermediary the information is necessary in developing and maintaining the operations of patient care facilities and activities.

A160.1, Benefits.--For services furnished after June 30, 1981 a dentist qualifies as a "physician" if he is a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions. Such services include any otherwise covered service that may legally and alternatively be performed by doctors of medicine, osteopathy and dentistry, e.g., dental examinations to detect infections prior to certain surgical procedures, treatment of oral infections and interpretations of diagnostic X-ray examinations in connection with covered services. Because the general exclusion of payment for dental services has not been withdrawn, payment for the services of dentists is also limited to those procedures which are not primarily provided for the care, treatment, removal, or replacement of teeth or structures directly supporting teeth. (Section 232.13 also concerns this exclusion.) The coverage or exclusion of any given dental service is not affected by the professional designation of the "physician" rendering the service; i.e., an excluded dental service remains excluded and a covered dental service is still covered whether furnished by a dentist or a doctor of medicine or osteopathy.

Cross-refer: §§160.1 and 232.13.

A160.1B1 Physician.—The phrase "doctor of pediatry or surgical chiropody" in Section 1861(r)(3) of the Social Security Act has been changed by the Omnibus Reconciliation Act of 1980 to read "doctor of podiatric medicine." Effective January 1, 1981, a podiatrist is considered a "physician" for the purpose of making required physician certification and recertification of medical necessity for Part A and Part B services if the podiatrist's performance of these functions is: (1) consistent with the policy of the institution or agency with respect to which he performs them; and (2) legally authorized by the State.

Effective January 1, 1981, a podiatrist is considered a "physician" for the purpose of establishing and periodically reviewing a home health plan of treatment if the podiatrist's performance of these functions is: (1) consistent with the policy of the institution or agency with respect to which he performs them; and (2) is legally authorized by the State.

Cross refer: Section 160.1B1, Section 219.4

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200. HOME HEALTH AGENCY

A home health agency is a public agency or private organization, or a subdivision of such an agency or organization, which meets the following requirements:

A. It is primarily engaged in providing skilled nursing services and other therapeutic services, such as physical, speech, or occupational therapy, medical social services, and home health aide services. A public or voluntary nonprofit health agency may qualify by--

1. furnishing both skilled nursing and at least one other therapeutic service directly to patients, or

2. furnishing directly either skilled nursing services or at least one other therapeutic service and having arrangements with another public or voluntary nonprofit agency to furnish the services which it does not provide directly.

A proprietary agency can qualify only by providing directly both skilled nursing services and at least one other therapeutic service.

B. It has policies established by a professional group associated with the agency or organization (including at least one physician and at least one registered professional nurse) to govern the services, and provides for supervision of such services by a physician or a registered professional nurse.

C. It maintains clinical records on all patients.

D. It is licensed in accordance with State or local law or is approved by the State or local licensing agency as meeting the licensing standards (where State or local law provides for the licensing of such agencies or organizations).

E. It meets other conditions found by the Secretary of Health, Education, and Welfare to be necessary for health and safety.

A private organization which is not exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954 (sometimes referred to as a "proprietary" organization) must be licensed pursuant to State law. If the State has no licensing law for such organizations, a proprietary agency cannot participate in the health insurance program.

For services under hospital insurance, the term "home health agency" does not include any agency or organization which is primarily for the care and treatment of mental disease. There is no such restriction under supplementary medical insurance.

200.1 Subdivision of Agencies.--When the subdivision of an agency, such as the home care department of a hospital or the nursing division of a health department, wishes to participate as a home health agency, the subdivision must meet the conditions of participation and must maintain records in such a way that subdivision activities and expenditures attributable to services provided under the health insurance program are identifiable.

200.2 Arrangements by Home Health Agencies.--

A. A home health agency may have others furnish covered items or services through arrangements under which receipt of payment by the home health agency for the services discharges the liability of the beneficiary or any other person to pay for the services. Whether the services and items are furnished by the home health agency itself or by another agency under arrangements both must agree not to charge the patient for covered services and items and must also agree to return money incorrectly collected.

In permitting home health agencies to furnish services under arrangements it was not intended that the agency merely serve as a billing mechanism for the other party. Accordingly, for services provided under arrangements to be covered the agency must exercise professional responsibility over the arranged-for services.

The agency's professional supervision over arranged-for services requires application of many of the same quality controls as are applied to services furnished by salaried employees. The agency must accept the patient for treatment in accordance with its admission policies, maintain a complete and timely clinical record on the patient which includes diagnosis, medical history, physician's orders, and progress notes relating to all services received; maintain liaison with the attending physician with regard to the progress of the patient and to assure that the required plan of treatment is periodically reviewed by him; secure from the physician the required certifications and recertifications; and see to it that the medical necessity of such services is reviewed on a sample basis by the agency's staff or an outside review group.

There are 3 situations in which a home health agency may have arrangements with another health organization or person to provide home health services to patients:

1. Where an agency or organization, in order to be approved to participate in the program, makes arrangements with another agency or organization to provide the nursing or other therapeutic services which it cannot provide directly.

2. Where an agency or organization, which is already approved for participation, makes arrangements with others to provide services it does not provide.

3. Where an agency or organization, which is already approved for participation, makes arrangements with a hospital, skilled nursing facility, or rehabilitation center for services on an outpatient basis because the services involve the use of equipment which cannot be made available to the patient in his place of residence.

B. If an agency's subdivision (acting in its capacity as a home health agency) makes an arrangement with its parent agency for the provision of these items and/or services, there need not be a contract or formal agreement. If, however, the arrangement is made between the home health agency and another provider participating in the health insurance program (hospital, skilled nursing facility, or home health agency, and, in the case of physical therapy services, clinics, rehabilitation agencies, and public health agencies), there must be a written statement regarding the services to be provided and the financial arrangements.

C. If the arrangements are with an agency or organization which is not a qualified provider of services, there must be a written contract which includes all of the following:

1. A description of the services to be provided.

2. The duration of the agreement and how frequently it is to be reviewed.

3. A description of how personnel will be supervised.

4. A statement that the contracting organization will provide its services in accordance with the plan of treatment established by the patient's physician in conjunction with the home health agency's staff.

5. A description of the contracting organization's standards for personnel, including qualifications, functions, supervision, and inservice training.

6. A description of the method of determining reasonable costs and reimbursement by the home health agency for the specific services to be provided by the contracting organization.

7. An assurance that the contracting organization will comply with title VI of the Civil Rights Act.

D. If a home health agency notifies a beneficiary of noncoverage of services which another party has been furnishing under arrangements entered into by the agency, the initial notice, in and of itself, does not negate the contract between the agency and the other party. Unless the evidence shows that the contract has been formally terminated, the beneficiary is considered to still be the agency's patient and the other party to be the representative of the agency. Consequently, if upon initial notice that a service is no longer covered the other party continues to provide services to the patient, the other party is considered to be furnishing the services under arrangements with the home health agency, absent evidence to the contrary. Thus, if a beneficiary appeals the noncoverage of any or all of the arranged for services furnished after the notice, and a ruling is made in favor of the beneficiary, those services ruled on favorably would be reimbursable since they would constitute services furnished under arrangements by a certified home health

agency. If the denial is sustained, however, the other party cannot bill the beneficiary for the denied services since the home health agency, not the other party, is responsible for the care rendered.

200.3 Rehabilitation Centers.-- When the services are of such a nature that they cannot be administered at the patient's residence and are administered at a rehabilitation center which is not participating in the program as a hospital, skilled nursing facility, or home health agency, the rehabilitation center must meet certain standards. The physical plant and equipment of such a rehabilitation center must meet all applicable State and local legal requirements for construction, safety, health, and design, including safety, sanitation and fire regulations, building codes and ordinances.

Covered and Noncovered Home Health Agency Services

203. COVERED HOME HEALTH SERVICES.

Prior to July 1, 1981, to qualify for home health benefits under either Part A or Part B of the program a beneficiary must be confined to his or her home, under the care of a physician, and in need of skilled nursing services on an intermittent basis, physical therapy or speech therapy. Beneficiaries who require one or more of these services in the treatment of their illness or injury and otherwise qualify for home health benefits are eligible to have payment made on their behalf for the skilled nursing, physical or speech therapy they need, and for any of the other home health services specified in the law. These services include occupational therapy, medical social services, the use of medical supplies and medical appliances, and the part-time or intermittent services of home health aides. Conversely, patients who do not require intermittent skilled nursing or physical or speech therapy cannot qualify to have payment made under the program for any home health services furnished them. Effective July 1, 1981, a person may qualify for home health benefits based on his or her need for occupational therapy or skilled nursing services on an intermittent basis, physical therapy or speech therapy.

Effective December 1, 1981, occupational therapy is eliminated as a basis for entitlement to home health services. However, if a person has otherwise qualified for home health services because of the need for skilled nursing care, physical therapy or speech therapy, the patient's eligibility for home health services may be extended solely on the basis of the continuing need for occupational therapy. (See SS 208-212 for additional conditions for coverage of home health services.)

Since Medicare is an insurance program, insured individuals who meet the home health coverage requirements are entitled by law to have reimbursement made for reasonable and necessary covered home health services they need. Accordingly, when a physician orders services for a beneficiary, that beneficiary is entitled to have the costs of such services reimbursed under the program without regard to whether there is someone available in the home to furnish them. However, where it comes to the attention of the intermediary that a family member or other caring person is or will be providing services that adequately meet the patient's needs, it would not be reasonable and necessary for home health agency personnel to furnish duplicative services. For example, if on the evaluation visit the agency determines that a family member has been or will be bathing the patient several times a week and this family member is or will be continuing to meet the patient's personal needs, it would not be reasonable and necessary for the home health agency to furnish such services.

The following sections discuss in detail the covered home health services and the conditions which must be met before reimbursement may be made for such services furnished a beneficiary by a participating home health agency or others under arrangements with such an agency. (See § 200.2.) The salaries of home health agency personnel employed to assist in the overall operation of the program, such as psychologists, inhalation therapists, and nutrition personnel, are includable in computing the agency's reimbursable costs. Payment may not be made for the individual visits by such personnel to a beneficiary's home.

204. SKILLED NURSING CARE

Skilled nursing care is a covered home health service and is reimbursable under the Medicare program provided that all of the following conditions are met:

A. The services are ordered by and included in the plan of treatment established by the physician for the patient (see § 208.3);

The following section [illegible]

[illegible]

B. The services are required on an intermittent basis (see § 204.1);

C. The services must be performed by or under the direct supervision of a licensed nurse (R.N., L.P.N., or L.V.N.) to assure the safety of the patient and to achieve the medically desired result (see § 204.2); (see § 204.5 for exception in the case of services by student nurses); and

D. The services are reasonable and necessary to the treatment of an illness or injury (see § 204.3).

Assuming that all the above conditions and all the other requirements for home health benefits are met, reimbursement can be made under the program for the skilled nursing care required by a beneficiary without regard to whether the beneficiary had a terminal, chronic, or acute illness, his or her condition is stabilized or unstabilized, or the need for skilled nursing service may extend over a long period of time.

However, since many individuals with stabilized or chronic conditions and possibly at some stage of their illnesses, individuals with terminal conditions, require only the services of a home health aide, the intermediary should assure that the skilled nursing care prescribed (as well as any other covered service they may receive) is reasonable and necessary to the treatment of the illness or injury. (See § 204.3)

204.1 Definition of "Intermittent".-- To meet the requirement for "intermittent" skilled nursing care, an individual must have a medically predictable recurring need for skilled nursing services. In most instances, this definition will be met if a patient requires a skilled nursing service at least once every 60 days.

Since the need for "intermittent" skilled nursing care makes the individual eligible for other covered home health services, the intermediary should evaluate each claim involving skilled nursing services furnished less frequently than once every 60 days. In such cases, payment should be made only if documentation justifies a recurring need for reasonable, necessary, and medically predictable skilled nursing services. The following are examples of the need for infrequent, yet intermittent, skilled nursing services:

1. The patient with an indwelling silicone catheter who generally needs a catheter change only at 90-day intervals;

2. The person who experiences a fecal impaction due to the normal aging process (i.e., loss of bowel tone, restrictive mobility, and a breakdown in good health habits) and must be manually disimpacted. Although these impactions are likely to recur, it is not possible to pinpoint a specific timeframe; or

3. The blind diabetic who self-injects insulin may have a medically predictable recurring need for a skilled nursing visit at least every 90 days. These visits, for example, would be to observe and determine the need for changes in the level and type of care which have been prescribed, thus supplementing the physician's contacts with the patient. (See Coverage Issues Appendix, § HHA-1.)

Where the need for "intermittent" skilled nursing visits is medically predictable but a situation arises after the first visit making additional visits unnecessary, e.g., the patient is institutionalized or dies, the one visit would be reimbursable. However, a one-time order; e.g., to give gamma globulin following exposure to hepatitis, would not be considered a need for "intermittent" skilled nursing care since a recurrence of the problem which would require this service is not medically predictable.

Although most patients require services no more frequently than several times a week, Medicare will pay for part-time (as defined in § 206.6) medically reasonable and necessary skilled nursing care 7 days a week for a short period of time (2-3 weeks). There may also be a few cases involving unusual circumstances where the patient's prognosis indicates the medical need for daily skilled services will extend beyond 3 weeks. As soon as the patient's physician makes this judgment, which usually should be made before the end of the 3 week period, the home health agency must forward medical documentation justifying the need for such additional services and include an estimate of how much longer daily skilled services will be required.

A person expected to need more or less full-time skilled nursing care over an extended period of time; i.e., a patient who requires institutionalization, would usually not qualify for home health benefits.

204.2 Reimbursable Skilled Nursing Care.-- Reimbursable skilled nursing care consists of those services reasonable and necessary to the treatment of an illness or injury (see § 204.3) which must be performed by or under the direct supervision of a licensed nurse (R.N. or L.P.N. or L.V.N.) if the safety of the patient is to be assured and the medically desired result achieved. (See § 204.4E2 and § 204.5 for special exceptions.)

A. In determining whether a service requires the skill of a nurse, consideration must be given to both the inherent complexity of the service and the condition of the patient.-- In many instances a service may be classified as a skilled nursing service on the basis of its complexity alone, e.g., intravenous and intramuscular injections or insertion of catheters. (See §§ 204.4E and 204.4H(1).) In others the classification will require a consideration of both the nature of the services and the condition of the patient, i.e., in a given case the patient's condition may be such that a service which would normally be classified as unskilled can only be provided safely and effectively by a skilled individual. For example, it is possible that in some situations a patient who has had rectal surgery may be given an enema safely and effectively only by a nurse.

B. A service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a licensed nurse. Where the nature of a service is such that it can be safely and effectively performed (or self-administered) by the average nonmedical person without the direct supervision of a licensed nurse, the service cannot be regarded as a skilled nursing service even though a licensed nurse actually provides the service. For example, the giving of a bath does not generally require the skills of a nurse. Consequently, it would not constitute a skilled nursing service even though it is performed by a nurse.

C. The fact that a skilled nursing service is taught to the patient does not negate the skilled aspect of the service when performed by the nurse. For example, it is customary to teach the patient and/or family member the skills required to administer insulin injections safely and effectively. Once the patient or other nonmedical person has mastered these skills, he is to all intents and purposes functioning as a skilled person when administering or self-administering the injection. Consequently, if a patient is unable to learn these skills or is physically or mentally incapable of performing the service for himself, e.g., he is blind, senile, or spastic, and there is no one else willing and able to learn and perform the service for him, the administration of the injections by a nurse in such situations would constitute a skilled nursing service. These situations are to be distinguished from those involving services which can be administered safely and effectively by the average nonmedical person on the basis of a relatively simple explanation and demonstration of the service, e.g., use of IPPB machine. In the former situation of teaching injection techniques, both the teaching of the service and the performance of the service are highly skilled so that an individual is considered capable of performing the service only after an intensive training course which includes a period of supervised practical application of the training. In the latter situation, the service itself does not require the skills of a nurse; however, since the knowledge required to give the instructions and demonstrations needed in connection with the performance of the service is not within the general knowledge of the average nonmedical person, the provision of such instruction and demonstration by a nurse is considered a skilled nursing service.

D. If a service is one which could be performed by the average nonmedical person, the fact that a competent person is not available in the home to perform the service would not convert the service to a skilled nursing service. For example, an individual who suffers from constipation requires an enema from time to time. There is, of course, no doubt that the enema is of great importance to such an individual. However, since it can be performed by the average nonmedical person, the fact that such a person is not available in the home to provide this service does not change it to a skilled nursing service.

(See A. above for situations where a service which could normally be performed by the average nonmedical person requires the skills of a licensed nurse because of the patient's condition.)

204.3 Reasonableness of and Necessity for Skilled Nursing Care.--Reimbursement may be made for skilled nursing services required by an individual only if such services are found to be reasonable and necessary to the treatment of the individual's illness or injury. To be considered reasonable and necessary for the treatment of an illness or injury, the services furnished must be consistent with the nature and severity of the individual's illness or injury, his particular medical needs and accepted standards of medical practice. Services directed to the prevention of illness or injury are not covered under the program except as noted below in §204.4.

204.4 Application of Guidelines to Nursing Services Furnished in the Home Setting.--

A. Observation and Evaluation.--Where a physician concludes that a patient's condition is such that the reasonable probability exists that significant changes may occur which would require his or her skills or the skills of a licensed nurse to evaluate the need for modification of the plan of treatment or to consider institutionalization, it would be appropriate for the physician to request a nurse to supplement his or her personal contacts with the patient. (While the nurse shares to some extent the physician's ability to evaluate the need to change the plan of treatment or to consider hospitalization, only the physician may order needed changes or hospitalization.) Such visits would be reimbursable as skilled nursing visits as long as a need for such evaluation exists.

Usually, draining wounds would require the skilled observation and evaluation of a nurse since they carry a high probability of complications and infection necessitating early medical intervention and change of treatment. The symptoms of such an infection may be a rise in temperature, an increase in pulse rate and a change in the nature of the discharge from the wound. While the average nonmedical person may be able to make the individual observations required, only a nurse has the skill to evaluate their relationship to each other and determine whether they reflect a need for contacting the physician.

For patients with heart disease, the possibility of fluid build-up exists, but only a few actually experience a significant problem with fluid. In such cases the skills of a nurse would be required to evaluate the severity of the edema and the significance of any accompanying rise in weight, respiratory rate, blood pressure, or pulse for the purpose of determining whether the signs and symptoms have reached the point set by the doctor for giving an injection of a diuretic, or whether the patient requires a visit by the physician. On the other hand, visits made by a nurse to take the vital signs (temperature, pulse, respiration, and blood pressure) of a patient during a period of stability, e.g., the patient with compensated heart disease, would not be reimbursable as a skilled nursing service since such visits are not considered reasonable and necessary to the treatment of the individual's illness or injury.

In addition to the requirement that observation and evaluation services be necessary, the period of time for which these services continue to be rendered must be reasonable. Where there has been no significant change (e.g., no change in medication or vital sign stability, no recent exacerbation in the patient's condition) for a period of 3 weeks (or where the physician orders such services as infrequently as every 30 to 60 days) and no other necessary skilled nursing services are being furnished, nursing visits solely for observation and evaluation would not be considered reasonable and necessary. Once the patient's condition remains unchanged under circumstances just described, further observation and evaluation visits by a nurse would not be covered even though the home health agency feels that there is a possibility the patient's condition could undergo a significant change at some future point in time.

There is a possibility that some post operative cataract patients may develop complications during the immediate post operative period following a hospital stay of even normal duration. Payment is allowed where the physician prescribes a small number of nursing visits for observing and evaluating the patient's condition immediately following discharge to the home. However, should complicating secondary conditions be present or develop, additional visits are reimbursable upon appropriate documentation. On the other hand, visits made by a nurse solely for the purpose of providing nonskilled services, e.g., applying eye drops and ointments, would not be reimbursable. (See §204.2.)

(Note: Although it is appropriate, where a patient's condition warrants, for the physician to have a nurse supplement his or her personal contacts with the patient for purposes of evaluation and to determine the need for changes in the level and type of care which has been prescribed, such visits may not replace those of the physician. It is expected that an individual requiring a level of care which would make him or her eligible for home health benefits would need to be seen by the physician at least once every 60 days. Consequently, where the physician sees the patient less frequently than once every 60 days, a question would be raised as to whether the individual is really in need of the level of care which qualifies him or her for home health benefits.)

B. Teaching and Training Activities.--Teaching and training activities which require the skills or knowledge of a nurse constitute skilled nursing services. These include but are not limited to teaching or training the patient, a family member, or others to:

1. Give an injection (see H.1 below);

2. Irrigate a catheter (see E below);

3. Care for a colostomy or ileostomy;

4. Administer medical gases;

5. Prepare and follow a therapeutic diet;

6. Apply dressings to wounds involving prescription medications and aseptic techniques (see A above);

7. Carry out bladder training (see E.1 below);

8. Carry out bowel training. (Note: Teaching bowel training requires the skills of a nurse only when bowel incontinency exists.);

9. Perform activities of daily living (dressing, eating, personal hygiene, etc.) for himself through use of special techniques and adaptive devices where he has suffered a loss of function;

10. Align and position a bed-bound patient;

11. Perform transfer activities, e.g., from bed to bed, bed to chair or wheelchair, wheelchair to bathtub or toilet; and

12. Ambulate by means of crutches, walker, cane, etc.

In determining the reasonable and necessary number of teaching visits consideration must be given to whether the teaching provided in the home constitutes a reinforcement of teaching provided in an institutional setting or constitutes the initial instruction received by the patient. If it constitutes reinforcement of training previously received, fewer visits should normally be required than for initial training. However, this does not preclude payment for more than the average number of visits where the facts indicate that the ability of the patient to comprehend and utilize the teaching given in the hospital in the home setting is such that additional teaching visits to the home were required. Visits made solely to remind or emphasize to the patient or his family the need to follow the instructions provided do not require the skills of a nurse. However, visits by a nurse as part of an initial training program to supervise and evaluate the practical application of the training furnished would require the skills of a nurse and would be considered reasonable and necessary where the complexity of the service being taught indicates such visits are warranted; e.g., insulin injections or preparation of formula feedings for gastrectomy patients. If a physical therapist or occupational therapist is visiting the home it would not usually be necessary to have a licensed nurse visit the home to provide instruction in the use of supportive devices, self-care activities, body alignment and positioning, and transfer activities since such activities would generally be carried out by the physical therapist or occupational therapist as a part of the physical therapy or occupational therapy program established for the patient.

C. Supervisory Activities.—A nurse performs various types of supervisory services. Those which require her particular skill, knowledge, and judgment constitute skilled nursing service.

1. Direct Supervision of the Performance of a Skilled Nursing Service Performed by Other Than a Nurse.—The direct supervision provided by a licensed nurse of the performance of skilled nursing service by other than a nurse would constitute a skilled nursing service, e.g., supervising a student nurse in giving an intravenous or intramuscular injection. (See also B. above and §§ 218ff.)

2. Supervision by a Registered Nurse of Home Health Aide Services.—The fact that the conditions of participation require a R.N. to visit the patient's home at least every 2 weeks in order to provide general supervision to the aide and to evaluate the patient's continuing personal care needs does not affect the unskilled nature of the service rendered by the home health aide. Neither would such activities of the supervising nurse represent skilled nursing care of the patient. Consequently, such supervisory visits may not be billed as skilled nursing visits, but are considered an administrative cost of the agency. (See §§ 218ff.)

D. Therapeutic Exercises.—In some situations a patient's condition may be such that the required exercises could be safely and effectively performed by the patient, a home health aide or family member; in others, the same exercises can only be safely and effectively performed by a licensed nurse or a physical therapist. In a third situation, due to complications, the same exercise might require the unique skills of a physical therapist rather than of a licensed nurse. In light of this it is not possible to establish hard-and-fast rules as to when and under what circumstances a particular exercise program will require the skills of a licensed nurse. However, the following generalizations are pertinent to such decisions.

Usually, exercises which are not related to the restoration of a specific loss of function, e.g., general body conditioning exercises for bedridden patients, and repetitive exercises to improve gait, to increase endurance and to maintain function for individuals with stabilized or chronic conditions, e.g., passive exercises to maintain range of motion in paralyzed extremities may be performed safely and effectively by a home health aide or family member. (See § 205.1.) Conversely, it is expected that exercise programs which are a part of the active treatment of a specific disease state which has resulted in a loss or restriction of mobility evidenced by clinical notes showing the degree of motion lost and the degree restored, generally will require the skills of a physical therapist or licensed nurse.

In some situations, the program can be performed safely by either a licensed nurse or a physical therapist since both have a knowledge of anatomy, of the patient's degree of tolerance and pain, as well as the ability to observe and evaluate the results of such exercises. In others the unique skills of a qualified physical therapist would be required. For example, an exercise program required for a patient who has had a cerebral vascular accident (CVA) with severe sensory perception and motor defects would require the skills of a physical therapist. (See § 205.1.) On the other hand, an exercise program established by the physician after appropriate consultation with the physical therapist for a patient with a CVA with less severe residuals could be carried out safely and effectively by either a nurse or physical therapist. And in still other cases, the residuals of a CVA may be so mild that neither the skills of a nurse or physical therapist are needed to restore function.

E. Insertion and Sterile Irrigation of a Catheter.--The insertion and sterile irrigation of a catheter is a skilled nursing service and is considered reasonable and necessary where the individual has suffered a permanent or temporary loss of bladder control.

1. Bladder Training.--Where the loss of control necessitating the use of a catheter is temporary, visits made by the nurse to change the catheter should also include instruction of the patient and/or family in bladder training methods. (The actual carrying out of the bladder training, e.g., forcing fluids, or other measures do not require the skills of a nurse.) After the catheter has been removed, a reasonable number of visits by the nurse may be necessary to observe and evaluate the effectiveness with which the bladder training has been carried out, e.g., the degree to which the bladder is emptying. See B above.

2. Use of Male Orderlies.--It is established practice in the medical field to have urinary catheters inserted in male patients by male orderlies who have been taught this skill or by the physician. In recognition of this practice, this service by the male orderly may be considered a skilled nursing service even though not performed under the direct supervision of a licensed nurse. This constitutes a special exception to the definition of skilled nursing care and should not, therefore, be used as a precedent.

F. Enemas.--Usually, the giving of an enema does not require the skills of a nurse. (See §§ 204.1, 204.2A and D above.)

G. Baths.--Usually, the giving of a bath does not require the skills of a nurse.

H. Administration of Medications.--

1. Intravenous and Intramuscular Injections.--Intramuscular and intravenous injections of medications constitute skilled nursing services. (See § 204.2C above.) However, if the drug injected is not considered an effective treatment for the condition given, or a medical reason does not exist for providing it by injection rather than by mouth, the injection is not considered reasonable and necessary to the treatment of the individual's illness. Similarly, medication administered for the treatment of a disease which exceeds the frequency or duration of injections indicated by accepted standards of medical practice as an appropriate level of care for that condition would be considered reasonable and necessary to the treatment of the patient's illness only where extenuating circumstances exist which justify the need for the additional injections. Also, if the patient or a member of his family has been taught to administer an intramuscular injection it would not be deemed reasonable and necessary to have a nurse administer the injection. Intravenous injections may only be given by a professional medical person. The drugs and biologicals injected are specifically excluded from coverage under the home health benefit.

a. Vitamin B-12 Injections.--Vitamin B-12 injections are considered specific therapy only for the following conditions:

(1) Certain Anemias.--Pernicious anemia; megaloblastic anemias, macrocytic anemias; fish tapeworm anemia;

(2) Certain Gastrointestinal Disorders.--Gastrectomy; malabsorption syndromes such as sprue and idiopathic steatorrhea; surgical and mechanical disorders such as resection of the small intestine, strictures, anastomoses and blind loop syndrome;

(3) Certain Neuropathies.--Posterolateral sclerosis; other neuropathies associated with pernicious anemia; during the acute phase or acute exacerbation of a neuropathy due to malnutrition and alcoholism.

Scientific studies have shown that in an individual with documented pernicious anemia caused by vitamin B-12 deficiency, an intramuscular or subcutaneous injection of vitamin B-12 at a dose of from 100 to 1,000 micrograms no more frequently than once monthly is the accepted, necessary, and reasonable dosage schedule for maintenance treatment. More frequent injections would be appropriate in the initial or acute phase of the disease until it has been determined through laboratory tests that the patient can be sustained on a maintenance dosage.

It is not customary to teach nonmedical persons to administer these injections.

b. Insulin Injections.--Insulin injections are specific therapy for diabetes. However, if the individual or a family member has been taught to give the injection it is not considered reasonable and necessary to the treatment of the individual's illness to have a nurse administer such injections. (See § 204.2C.) If the patient is mentally and physically able to be taught to give himself the injection but refuses to learn to do so, visits by a nurse to administer the injections would also not be considered reasonable and necessary to the treatment of his illness and, consequently, would not be reimbursable under the program. If a patient has a psychological block to giving himself an insulin injection, he would be considered mentally unable to be taught to render the self-injection.

2. Oral Medications.--Usually, the administration of oral medications does not require the skills of a licensed nurse in the home setting. While in the institutional setting the skills of a nurse may be required to detect and evaluate sudden undesirable side effects or reactions to a drug regimen being established, the individual in the home setting has usually reached the point where his medications have been regulated so that any side effects would be minimal and a nonmedical person could detect and report them to the physician. However, this would not preclude payment in the unusual situation where the complexity of the patient's condition and the number of drugs prescribed would require the skills of a nurse to detect and evaluate side effects or reactions providing, of course, the case is well documented. Placing medication in envelopes, cups, etc., to assist patients in remembering to take them would not constitute a skilled nursing service.

3. Eye Drops and Topical Ointments.--The administration of eye drops and topical ointments does not require the skills of a nurse.

I. Intravenous and Hypodermoclysis Feedings.--These feedings require the skills of a nurse. However, due to the time required for the feedings and the fact that individuals requiring such feedings generally require a higher level of care than can be provided in the home setting, it is expected that they will be furnished in the home only in those situations where the individual is waiting to be institutionalized or is in the terminal stages of an illness.

J. Skin Care.--

1. Extensive Decubitus Ulcers or Other Widespread Skin Disorder.--The existence of extensive decubitus ulcers or other widespread skin disorder may necessitate skilled care. The principal indication of whether skilled care is required would be the physician's orders for treating the skin, rather then the patient's diagnosis.

2. Routine Prophylactic and Palliative Skin Care.--Activities such as bathing the skin, applying creams, etc., do not constitute skilled services. Nor does the presence of a small decubitus ulcer, rash, or other relatively minor skin irritation generally indicate a need for skilled care.

204.5 Student Nurses.--Some home health agencies participate in training programs in which they utilize student nurses enrolled in a school of nursing to perform skilled nursing services in the home setting. If a home health agency participating in such a training program assigns a student nurse to provide skilled nursing services in the patient's home, the costs of her services are reimbursable as skilled nursing care. The services must be performed under the general supervision of a registered professional nurse who is either an employee of the home health agency or the school of nursing in which the student is enrolled. However, the supervising nurse need not accompany the student on each visit. This represents a special exception to the requirement that skilled nursing services must be rendered by or under the direct supervision of a licensed nurse and should not, therefore, be used as a precedent. (See § 218.2 for counting of visits when the supervisor accompanies the student on a visit.)

204.6 Psychiatric Nursing under Home Health.--Determinations as to whether a particular service constitutes a skilled nursing service must ordinarily be made on a case-to-case basis. As a general rule, however, the evaluation and psychotherapy needed by a patient suffering from a diagnosed psychiatric disorder which necessitated active treatment in an institution would require the skills of a psychiatrically trained nurse and consequently would be reimbursable. (A psychiatrically trained nurse is a nurse who has special training and/or experience beyond the standard curriculum required for the R.N. Examples of such special training or experience would include a masters degree in psychiatric or mental health nursing or equivalent training, experience as a member of the nursing staff in an active treatment unit of a psychiatric hospital (this experience would be beyond that gained as part of a registered nurse's training), or experience as a member of an outpatient mental health clinic or hospital.) The special training of such nurses enables them to interpret the underlying meaning in the patient's actions and evaluate the need for the psychiatrist to change the plan of treatment or to reschedule visits to the psychiatrist's office. It is expected that an individual whose psychiatric disorder is severe enough to require the special skills of a psychiatric nurse will be under the care of a psychiatrist with the plan of treatment established and reviewed by that psychiatrist.

If the visiting nurse has not been trained in psychiatric care, visits to evaluate and give psychotherapy would not be reimbursable since they are not deemed "reasonable" to the treatment of the patient's illness. However, if a psychiatrist prescribes intramuscular injections of fluphenazine, a behavior modifier, as the entire plan of treatment for a schizophrenic patient, the visits by the nurse not "psychiatrically" trained would be reimbursable.

The law precludes an agency which is primarily for the care and treatment of mental diseases from participating in the Part A program. However, this exclusion would not preclude payment under Part A where psychiatric nursing is furnished by an agency which is not primarily for the care and treatment of mental diseases.

205. PHYSICAL, SPEECH, AND OCCUPATIONAL THERAPY

Physical, speech, and occupational therapy furnished by a home health agency or by others under an arrangement with and under the supervision of such an agency are covered provided that certain conditions are met.

205.1 Physical Therapy

A. Definition.--To constitute physical therapy services, the services must be of such a level of complexity and sophistication, or the patient's condition must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under his supervision.

Services related to activities for the general good and welfare of patients, e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation do not constitute physical therapy services for Medicare purposes.

The services furnished beneficiaries must meet the definition of physical therapy where the entitlement to benefits is at issue. Since the outpatient physical therapy benefit under Part B provides coverage only of physical therapy services, payment can be made only for those services which constitute physical therapy.

B. Reasonable and Necessary.--To be reimbursable physical therapy must relate directly and specifically to an active written treatment regimen established by the physician after any needed consultation with the qualified physical therapist and must be reasonable and necessary to the treatment of the individual's illness or injury. To be considered reasonable and necessary the following conditions must be met:

(a) The services must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition,

(b) there must be an expectation that the condition will improve significantly in a reasonable (and generally predictable) period of time based on the assessment made by the physician of the patient's restoration potential after any needed consultation with the qualified physical therapist or the services must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state, and

(c) the amount, frequency, and duration of the services must be reasonable.

Claims for physical therapy services denied because they are not considered reasonable and necessary under section 1862(a)(1) should be considered under the waiver of liability provision in § 1879 of the act. (See §§ 260ff.)

1. Restorative Therapy.--To constitute physical therapy a service must, among other things, be reasonable and necessary to the treatment of the individual's illness. If an individual's expected restoration potential would be insignificant in relation to the extent and duration of physical therapy services required to achieve such potential the physical therapy would not be considered reasonable and necessary. In addition, there must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time. If at any point in the treatment of an illness it is determined that the expectations will not materialize the services will no longer be considered reasonable and necessary.

2. Maintenance Program.--The repetitive services required to maintain function generally do not involve complex and sophistcated physical therapy procedures, and consequently the judgment and skill of a qualified physical therapist are not required for safety and effectiveness. However, in certain instances the specialized knowledge and judgment of a qualified physical therapist may be required to establish a maintenance program. For example, a Parkinson patient who has not been under a restorative physical therapy program may require the services of a physical therapist to determine what type of exercises

2. Maintenance Programs.--The repetitive services required to maintain function generally do not involve complex and sophisticated physical therapy procedures, and consequently the judgment and skill of a qualified physical therapist are not required for safety and effectiveness. However, in certain instances the specialized knowledge and judgment of a qualified physical therapist may be required to establish a maintenance program. For example, a Parkinson patient who has not been under a restorative physical therapy program may require the services of a physical therapist to determine what type of exercises will contribute the most to maintain the patient's functional level.

In such situations the initial evaluation of the patient's needs, the designing by the qualified physical therapist of a maintenance program which is appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician, the instruction of the patient, family members, or home health aides in carrying out its program and such infrequent reevaluations as may be required would constitute physical therapy. However, since the need for a reevaluation visit(s) will depend, for the most part, on a change in the patient's condition which cannot be predicted at the time the maintenance program is instituted, the visit by the qualified physical therapist to establish a maintenance program would be covered as a home health service only if the individual also requires covered skilled nursing services or speech therapy. If he does not, the visit would be covered only as an outpatient physical therapy service. (See § 219.4). Where a patient has been under a restorative physical therapy program, the physical therapist should regularly be reevaluating the condition and adjusting any exercise program in which the patient is engaged. Consequently, when it is determined that no further restoration is possible, the physical therapist should have already designed the maintenance program required and instructed the patient, his family members, or home health aides in the carrying out of the program. Therefore, where a maintenance program is not established until after the restorative physical therapy program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage under § 1862(a)(1).

C. Application of Guidelines.--The following discussion illustrates the application of the above guidelines to the more common modalities and procedures utilized in the treatment of patients:

1. Hot Pack Hydrocollator Infra-Red Treatments, Paraffin Baths and Whirlpool Baths.--Heat treatments of this type and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. However, in a particular case the skills, knowledge, and judgment of a qualified physical therapist might be required in such treatments or baths, e.g., where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, or other complications. Also, if such treatments are given prior to but as an integral part of a skilled physical therapy procedure, they would be considered part of the physical therapy service.

2. Gait Training.--Gait evaluation and training furnished a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality require the skills of a qualified physical therapist. However, if gait evaluation and training cannot reasonably be expected to improve significantly the patient's ability to walk, such services would not be considered reasonable and necessary. Repetitious exercises to improve gait or maintain strength and endurance and assistive walking, such as provided in support for feeble or unstable patients are appropriately provided by supportive personnel, e.g., aides or nursing personnel, and do not require the skills of a qualified physical therapist.

3. Ultrasound, Shortwave, and Microwave Diathermy Treatments.--These modalities must always be performed by or under the supervision of a qualified physical therapist and therefore such treatments constitute physical therapy.

4. Range of Motion Tests.--Only the qualified physical therapist may perform range of motion tests and, therefore, such tests would constitute physical therapy.

5. Therapeutic Exercises.--Therapeutic exercises which must be performed by or under the supervision of the qualified physical therapist or by a qualified physical therapy assistant under the general supervision of a qualified physical therapist due either to the type of exercise employed or to the condition of the patient would constitute physical therapy. Range of motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease which has resulted in a loss or restriction of mobility (as evidenced by physical therapy notes showing the degree of motion lost and the degree to be restored) and such exercises either because of their nature or the condition of the patient may only be performed safely and effectively by or under the supervision of a qualified physical therapist. Generally, range of motion exercises which are not related to the restoration of a specific loss of function but rather are related to the maintenance of function (see B.2.) do not require the skills of a qualified physical therapist.

1. Hot Pack, Hydrocollator, Infra-Red Treatments and Whirlpool Baths.--Heat treatments of this type and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. However, in a particular case the skills, knowledge and judgment of a qualified physical therapist might be required in the giving of such treatments or baths, e.g., where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, or other complications. Also, if such treatments are given as a prerequisite to a skilled physical therapy procedure, they would be considered part of the physical therapy service.

2. Gait Training.--Gait evaluation and training furnished a patient whose ability to walk has been impaired by neurological, muscular or skeletal abnormality requires the skills of a qualified physical therapist and would constitute physical therapy provided that it can reasonably be expected to significantly improve the patient's ability to walk. Repetitious exercises to improve gait, maintain strength, endurance and assistive walking, such as provided in support for feeble or unstable patients, does not require the skills of a qualified physical therapist.

3. Ultrasound, Shortwave and Microwave Diathermy Treatments.--These modalities must always be performed by or under the supervision of a qualified physical therapist, and would therefore constitute physical therapy if they are in fact so performed.

4. Therapeutic Exercises.--Therapeutic exercises which must be performed by or under the supervision of the qualified physical therapist due either to the type of exercise employed or to the condition of the patient would constitute physical therapy (see 5. below).

5. Range of Motion.--Only the qualified physical therapist may perform range of motion tests and, therefore, such tests would constitute physical therapy. Range of motion exercises, on the other hand, constitute physical therapy only when they are part of the active treatment of a specific disease state which has resulted in a loss or restriction of mobility (as evidenced by physical therapy notes showing the degree of motion lost and the degree to be restored) and such exercises either because of their nature or the condition of the patient may be performed safely and effectively only by a qualified physical therapist or under his supervision. Generally speaking, range of motion exercises which are not related to the restoration of a specific loss of function and passive exercises to maintain range of motion in paralyzed extremities do not require the skills of a qualified physical therapist.

205.2 Occupational Therapy.--

A. General.—Occupational therapy is medically prescribed treatment concerned with improving or restoring functions which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning. Such therapy may involve:

1. the evaluation, and reevaluation as required, of a patient's level of function by administering diagnostic and prognostic tests;

2. the selection and teaching of task-oriented therapeutic activities designed to restore physical function, e.g., use of woodworking activities on an inclined table to restore shoulder, elbow and wrist range of motion lost as a result of burns;

3. the planning, implementing, and supervising of individualized therapeutic activity programs as part of an overall "active treatment" program for a patient with a diagnosed psychiatric illness, e.g., the use of sewing activities which require following a pattern to reduce confusion and restore reality orientation in a schizophrenic patient;

4. the planning and implementing of therapeutic tasks and activities to restore sensory-integrative function, e.g., providing motor and tactile activities to increase sensory input and improve response for a stroke patient with functional loss resulting in a distorted body image;

5. the teaching of compensatory techniques to improve the level of independence in the activities of daily living, e.g., teaching a patient who has lost the use of an arm how to pare potatoes and chop vegetables with one hand, teaching an upper extremity amputee how to functionally utilize a prosthesis, or teaching a stroke patient new techniques to enable him to perform feeding, dressing, and other activities as independently as possible;

6. the designing, fabricating, and fitting of orthotic and self-help devices, e.g., making a hand splint for a patient with rheumatoid arthritis to maintain the hand in a functional position or constructing a device which would enable an individual to hold a utensil and feed himself independently; and

7. vocational and prevocational assessment and training.

Only a qualified occupational therapist has the knowledge, training, and experience required to evaluate and, as necessary, reevaluate a patient's level of function, determine whether an occupational therapy program could reasonably be expected to improve, restore, or compensate for lost function and, where appropriate, recommend to the physician a plan of treatment. However, while the skills of a qualified occupational therapist are required to evaluate the patient's level of function and develop a plan of treatment, the implementation of the plan may also be carried out by a qualified occupational therapy assistant functioning under the general supervision of the qualified occupational therapist. ("General supervision" requires initial direction and periodic inspection of the actual activity; however, the supervisor need not always be physically present or on the premises when the assistant is performing services.)

B. *Coverage Criteria*.—To constitute covered occupational therapy for Medicare purposes the services furnished to a beneficiary must be (1) prescribed by a physician, (2) performed by a qualified occupational therapist or a qualified occupational therapy assistant under the general supervision of a qualified occupational therapist, and (3) reasonable and necessary for the treatment of the individual's illness or injury.

Occupational therapy designed to improve function is considered reasonable and necessary for the treatment of the individual's illness or injury only where an expectation exists that the therapy will result in a significant *practical* improvement in the individual's level of functioning within a reasonable period of time. Where an individual's improvement potential is insignificant in relation to the extent and duration of occupational therapy services required to achieve improvement, such services would not be considered reasonable and necessary and would thus be excluded from coverage under section 1862(a)(1). Where a valid expectation of improvement exists at the time the occupational therapy program is instituted, the services would be covered even though the expectation may not be realized. However, in such situations the services would be covered only up to the time at which it would have been reasonable to conclude that the patient is not going to improve. Once a patient has reached the point where no further significant practical improvement can be expected, the skills of an occupational therapist or occupational therapy assistant will not be required in the carrying out of any activity or exercise program required to *maintain function* at the level to which it has been restored. Consequently, while the services of an occupational therapist in *designing* a maintenance program and making infrequent but periodic evaluation of its effectiveness would be covered, the services of an occupational therapist or occupational therapy assistant in *carrying out* the program are not considered reasonable and necessary for the treatment of illness or injury and such services are excluded from coverage under section 1862(a)(1).

Generally speaking, occupational therapy is not required to effect improvement or restoration of function where a patient suffers a temporary loss or reduction of function (e.g., temporary weakness which may follow prolonged bedrest following major abdominal surgery) which could reasonably be expected to spontaneously improve as the patient gradually resumes normal activities. Accordingly, occupational therapy furnished in such situations would not be considered reasonable and necessary for the treatment of the individual's illness or injury and the services would be excluded from coverage by 1862(a)(1).

Occupational therapy may also be required for a patient with a specific diagnosed psychiatric illness. Where such services are required they would be covered, assuming the coverage criteria set forth above are met. However, it should be noted that where an individual's motivational needs are not related to a specific diagnosed psychiatric illness, the meeting of such needs does not usually require an individualized therapeutic program. Rather, such needs can be met through general activity programs or the efforts of other professional personnel involved in the care of the patient, patient motivation being an appropriate and inherent function of all health disciplines which is interwoven with other functions performed by such personnel for the patient. Accordingly, since the special skills of an occupational therapist or occupational therapy assistant are not required, an occupational therapy program for such individuals would not be considered reasonable and necessary for the treatment of an illness or injury, and services furnished under such a program would be excluded from coverage by 1862(a)(1).

As indicated, occupational therapy includes vocational and prevocational assessment and training. When services provided by an occupational therapist or assistant are related solely to specific employment opportunities, work skills or work settings, they are not reasonable or necessary for the diagnosis or treatment if an illness or injury and are excluded from coverage under the program by 1862(a)(1). However, care should be exercised in applying this exclusion, because the assessment of level of function and the teaching of compensatory techniques to improve the level of function, especially in activities of daily living, are services which occupational therapists provide for both vocational and nonvocational purposes. For example, an assessment of sitting and standing tolerance might be nonvocational for a mother of young children or a retired individual living alone, but would be a vocational test for a sales clerk. Training an amputee in the use of a prosthesis for telephoning is necessary for every-day activities as well as for employment purposes. Major changes in life style may be mandatory for an individual with a substantial disability; the techniques of adjustment cannot be considered exclusively vocational or nonvocational.

C. Supplies.--Occupational therapy frequently necessitates the use of various supplies, e.g., looms, ceramic tiles, leather, etc. The cost of such supplies may be included in the occupational therapy cost center.

205.3 Speech Pathology.--

A. General.--Speech pathology services are those services necessary for the diagnosis and treatment of speech and language disorders which result in communication disabilities. They must relate directly and specifically to a written treatment regimen established by the physician after any needed consultation with the qualified speech pathologist.

B. Reasonable and Necessary.--Speech pathology services must be reasonable and necessary to the treatment of the individual's illness or injury. To be considered reasonable and necessary, the following conditions must be met:

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition;

2. The services must be of such a level of complexity and sophistication, or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified speech pathologist. (See 42 CFR 405.1202(u)(1)(2).) (When the intermediary determines the services furnished were of a type that could have been safely and effectively performed only by qualified speech pathologists or under the supervision of a qualified speech pathologist, it should presume that such services were properly supervised. However, this assumption is rebuttable and, if in the course of processing claims the intermediary finds that speech pathology services are not being furnished under proper supervision, the intermediary should deny the claim and bring this matter to the attention of the Division of Health Standards and Quality of the HCFA regional office.)

3. There must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time based on the assessment by the physician of the patient's restoration potential after any needed consultation with the qualified speech pathologist, or the services must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state; and

4. The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. (The intermediary should consult with local speech pathologists or the State chapter of the American Speech-Language-Hearing Association in the development of any utilization guidelines.)

Claims for speech pathology services which are not reasonable and necessary should be considered denied under authority of section 1862(a)(1) and, therefore, are subject to the waiver of liability provisions in section 1879 of the act. (See §260ff.)

C. Application of Guidelines.--The following discussion illustrates the application of the above guidelines to the more common situations in which the reasonableness and necessity of speech services furnished is a significant issue.

1. Restorative Therapy.--If an individual's expected restoration potential would be insignificant in relation to the extent and duration of speech pathology services required to achieve such potential, the services would not be considered reasonable and necessary. In addition, there must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time. If at any point in the treatment of an illness or injury it is determined that the expectation will not materialize, the services will no longer constitute covered speech pathology services, as they would no longer be reasonable and necessary for the treatment of the patient's condition and would be excluded from coverage under section 1862(a)(1).

2. Maintenance Program.--After the initial evaluation of the extent of the disorder or illness, if the restoration potential is judged insignificant or, after a reasonable period of trial, the patient's response to treatment is judged insignificant or at a plateau, an appropriate functional maintenance program may be established. The specialized knowledge and judgment of a qualified speech pathologist may be required if the treatment aim of the physician is to be achieved; e.g., a multiple sclerosis patient may require the services of a speech pathologist to establish a maintenance program designed to fit the patient's level of function. In such a situation, the initial evaluation of the patient's needs, the designing by the qualified speech pathologist of a maintenance program which is appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician, the instruction of the patient and supportive personnel (e.g., aides or nursing personnel, or family members where speech pathology is being furnished on an outpatient basis) in carrying out the program, and such infrequent reevaluations as may be required, would constitute covered speech therapy. After the maintenance program has been established and instructions have been given for carrying out the program, the services of the speech pathologist would no longer be covered, as they would no longer be considered reasonable and necessary for the treatment of the patient's condition and would be excluded from coverage under section 1862(a)(1).

If a patient has been under a restorative speech pathology program, the speech pathologist should regularly reevaluate the condition and adjust the treatment program. Consequently, during the course of treatment the speech pathologist should determine when the patient's restorative potential will be achieved and, by the time the restorative program has been completed, should have designed the maintenance program required and instructed the patient, supportive personnel, or family members in the carrying out of the program. A separate charge for the establishment of the maintenance program under these circumstances would not be recognized. Moreover, where a maintenance program is not established until after the restorative speech pathology program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage under section 1862(a)(1) since the maintenance program should have been established during the active course of treatment.

D. Types of Services.--Speech pathology services can be grouped into two main categories: services concerned with diagnosis or evaluation and therapeutic services.

1. Diagnostic and Evaluation Services.--Unless excluded by section 1862(a)(7) of the law, these services are covered if they are reasonable and necessary. The speech pathologist employs a variety of formal and informal language assessment tests to ascertain the type, causal factor(s), and severity of the speech and language disorders. Reevaluation would be covered only if the patient exhibited a change in functional speech or motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated speech pathology. However, monthly reevaluations, e.g., a Porch Index of Communicative Ability (PICA) for a patient undergoing a restorative speech pathology program, are to be considered a part of the treatment session and could not be covered as a separate evaluation for billing purposes.

2. Therapeutic Services.--The following are examples of common medical disorders and resulting communication deficits which may necessitate active restorative therapy:

a. Cerebrovascular disease such as cerebral vascular accidents presenting with dysphagia, aphasia/dysphasia, apraxia, and dysarthria;

b. Neurological disease such as Parkinsonism or Multiple Sclerosis may exhibit dysarthria, dysphagia, or inadequate respiratory volume/control;

c. Mental retardation with disorders such as aphasia or dysarthria; and

d. Laryngeal carcinoma requiring laryngectomy resulting in aphonia may warrant therapy of the laryngectomized patient so he can develop new communication skills through esophageal speech and/or use of the electrolarynx.

NOTE: Many patients who do not require speech pathology services as defined above do require services involving nondiagnostic, nontherapeutic, routine, repetitive, and reinforced procedures or services for their general good and welfare; e.g., the practicing of word drills. Such services do not constitute speech pathology services for Medicare purposes and would not be covered since they do not require performance by or the supervision of a qualified speech pathologist.

206. OTHER HOME HEALTH SERVICES

206.1 Medical Social Services to Meet the Patient's Medically Related Social Needs.--Medical social services are those social services which contribute significantly to the treatment of a patient's medical condition. Medical social services are covered if they are prescribed by a physician and included in the patient's plan of treatment. Such services must, in the physician's professional judgment, be needed because social problems exist which are or will be an impediment to the effective treatment of the patient's medical condition or his rate of recovery.

The occurrence of social problems (economic, marital, environmental, etc.) can be varied in nature, degree, and timing. Depending on their severity, social problems can adversely affect a patient's response to a specifically prescribed medical regimen, rendering it less effective than desired, or even totally ineffective. Consequently, if social problems exist to the degree that they affect the progress or stability of the patient's medical condition, the services of a qualified medical or psychiatric social worker (or a qualified social work assistant who is supervised by a qualified social worker) may be required and, if so, are covered. However, if this is not the case and the medical social services furnished are of a type directed toward minimizing the problems any illness may create for any patient and his or her family (e.g., encouraging them to ventilate their concerns and providing them with reassurance) such services would not be considered reasonable and necessary to the treatment of the individual's illness or injury. The conditions of participation for home health agencies (42 CFR 405.1202 and 405.1226) describe the personnel qualifications, requirements for supervision, and required procedures for furnishing this service.

Covered services include, but are not limited to: (a) assessment of the social and emotional factors related to the patient's illness, need for care, response to treatment, and adjustment to care; (b) appropriate action to obtain case work services to assist in resolving problems in these areas; (c) assessment of the relationship of the patient's medical and nursing requirements to the individual's home situation, financial resources, and availability of community resources; and (d) counselling services required by the patient. Counselling services furnished to family members are not covered, even though the patient may benefit from them.

206.2 Services of a Home Health Aide.--The primary function of a home health aide is the personal care of a patient. The services of a home health aide are given under the supervision of a registered professional nurse, and if appropriate, a physical, speech, or occupational therapist. The assignment of a home health aide to a particular case must be made in accordance with a written plan of treatment established by a physician which indicates the patient's need for personnel care services. The specific personal care services to be provided by the home health aide must be determined by a registered professional nurse and not by the home health aide.

Personal care duties which may be performed by a home health aide include assistance in the activities of daily living; e.g., helping the patient to bathe, to get in and out of bed, to care for his hair and teeth, to exercise, and to take medications specifically ordered by a physician which are ordinarily self-administered, and retraining the patient in necessary self-help skills.

While the primary need of the patient for home health aide services furnished in the course of a particular visit may be for personal care services furnished by the aide, the home health aide may also perform certain household services which are designated to the home health aide in order to prevent or postpone the patient's institutionalization. These services may include keeping a safe environment in areas of the home used by the patient; e.g., changing the bed, light cleaning, rearrangements to assure that the beneficiary can safely reach necessary supplies or medication, laundering essential to the comfort and cleanliness of the patient, etc., seeing to it that the nutritional needs (which may include the purchase of food and assistance in the preparation of meals) of the patient are met, and washing utensils used in the course of the visit. If these household services are incidental and do not substantially increase the time spent by the home health aide, the cost of the entire visit would be reimbursable. Housekeeping services which would materially increase the amount of time required to be spent by the home health aide to make the visit above the amount of time necessitated by care for the patient are not reimbursable. Where another member of the household is an equally aged and feeble or ill person; e.g., an aged spouse or parent of the beneficiary, certain services performed by the home health aide may be advantageous to both members of the household and would nevertheless be reimbursable if the amount of time spent by the aide is not materially increased in order to service the nonbeneficiary member.

The discussion of part-time or intermittent services in §206.6 is also applicable to home health aides.

206.3 Medical Supplies (Except for Drugs and Biologicals) and the Use of Medical Appliances.--

A. Medical Supplies.--Medical supplies are items which, due to their therapeutic or diagnostic characteristics, are essential in enabling home health agency personnel to carry out effectively the care which the physician has ordered for the treatment or diagnosis of the patient's illness or injury. Certain items which, by their very nature, are designed only to serve a medical purpose are obviously considered to be medical supplies; e.g., catheters, needles, syringes, surgical dressings and materials used for dressings such as cotton gauze and adhesive bandages, and materials used for aseptic techniques. Other medical supplies include, but are not limited to, irrigating solutions, intravenous fluids, and oxygen.

Other items which are often used by persons who are not ill or injured may be considered medical supplies but only where (1) the item is recognized as having the capacity to serve a therapeutic or diagnostic purpose in a specific situation, and (2) the item is required as a part of the actual physician-prescribed treatment of a patient's existing illness or injury. For example, items which generally serve a routine hygienic purpose, such as soaps and shampoos, and items which generally serve as skin conditioners, such as baby lotion, baby oil, skin softeners, powders, lotions, etc., would not be considered medical supplies unless the particular item is recognized as serving a specific therapeutic purpose in the physician's prescribed treatment of the patient's existing skin (scalp) disease or injury. Where these conditions are met, such medical supplies are properly entered in item 21K of the SSA-1487.

Limited amounts of medical supplies may be left in the home between visits where repeated applications are required and will be rendered by the patient or by family members. Such supplies as needles, syringes, and catheters which require administration by a nurse should not be left in the home between visits.

B. Medical Appliances.-Medical appliances are items of medical equipment owned or rented by the home health agency which are placed in the home of the patient when a home health plan is in effect to facilitate his treatment and rehabilitation. Medical appliances are generally defined as items which can withstand repeated use, are primarily and customarily used to serve a medical purpose, and are generally not useful to a person in the absence of illness or injury. This definition would include (but is not limited to) such items as hospital beds, wheelchairs, crutches, trapeze bars, oxygen tents, and intermittent positive pressure breathing machines, i.e., items which would be considered presumptively as medical equipment under the definition of durable medical equipment, as discussed in § 220.1B1. In addition to such items, appliances which customarily serve a medical purpose but are also considerably useful to persons who are not ill or injured, appliances which customarily serve a nonmedical purpose but which may serve a medical purpose in a specific case, and appliances which are primarily designed to prevent illness or injury may also be considered as medical appliances under the home health benefit but only where: (1) the physician's plan of treatment specifically includes the use of such appliances in connection with the patient's treatment regimen and specifies any limitations which should be placed on the use of the appliance due to the patient's condition, and (2) the appliance may be expected to contribute meaningfully to the treatment of the illness or injury or to improve the functioning of a malformed body member. Examples of the type of appliances which may fall into this category include heat lamps, exercycles, flotation mattresses, bed baths, etc.

C. Drugs and Biologicals.-Drugs and biologicals are excluded from coverage as items or services administered by home health agencies, under both hospital insurance and medical insurance. They may, in certain cases, be covered under medical insurance, when administered by a physician as a part of his professional service, and are not capable of being self-administered.

206.4 Services of Interns and Residents.-Home health services include the medical services of interns and residents-in-training under an approved hospital teaching program (if the agency has an affiliation with or is under common control of a hospital providing such medical services). "Approved" means approved by the Council on Medical Education of the American Medical Association, or in the case of an osteopathic hospital, the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association and, in the case of an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association. Reimbursement is provided under Part B for other services hospital interns and residents furnish to beneficiaries receiving home health services.

Effective for accounting periods beginning after December 31, 1972, the services of interns and residents-in-training in the field of podiatry under a teaching program approved by the Council on Podiatry Education of the American Podiatry Association are covered under Part A on the same basis as the services of other interns and residents-in-training in approved teaching programs. For accounting periods beginning on or prior to December 31, 1972, coverage of these services is under Part B, on a reasonable cost basis.

206.5 Outpatient Services.--Outpatient services include any of the items or services described above which are provided under arrangements on an outpatient basis at a hospital, skilled nursing facility, rehabilitation center, or outpatient department affiliated with a medical school, and (1) which require equipment which cannot readily be made available at the patient's place of residence, or (2) which are furnished while he is at the facility to receive the services described in (1). The hospital, skilled nursing facility, or outpatient department affiliated with a medical school must all be qualified providers of services. However, there are special provisions for the use of the facilities of rehabilitation centers (see §200.3). The cost of transporting an individual to a facility cannot be reimbursed as home health services.

206.6 Part-Time or Intermittent Services.--Part-time or intermittent services of professional personnel and home health aides is usually service for a few hours a day several times a week. Occasionally, more service; i.e., up to 8 hours, may be provided for a limited period when recommended by the physician in the plan of treatment and when, because of unusual circumstances, neither the alternative of part-time care nor institutionalization is feasible.

Services of professional staff usually are provided less frequently and for shorter periods of time than are the services of home health aides. For physical, speech, occupational therapists and medical social workers, visits ordinarily should not exceed 1 hour. Home health aide visits usually last 1-3 hours a day and generally are provided 2 or 3 times a week. These figures are intended to be used as guidelines, not as limits on the coverage of aide services, since there are cases where longer and/or more frequent home health aide services would be reasonable and necessary (e.g., for a recent diabetic amputee who needs intensive personal care services, or for a patient with arthritis of the hands who needs assistance with colostomy care and irrigations as well as other personal care services). Accordingly, where these norms are exceeded, the agency must furnish documentation justifying the need for additional services. Where the need is justified, payment should be made.

For the very few ill patients who need extensive personal care services in addition to skilled services, Medicare will pay for part-time medically reasonable and necessary aide services 7 days a week for a short period of time (2-3 weeks). There may also be a few cases involving unusual circumstances where a patient's personal care needs extend beyond 3 weeks. For example, the patient's condition is terminal; or he or she has suffered a relapse which, while requiring more intensive care, either does not necessitate institutionalization or institutionalization cannot immediately be arranged. As soon as the physician makes this judgment which usually should be made before the end of the 3 week period, the home health agency must forward medical documentation justifying the need for such additional services and include an estimate of how much longer daily services will be required.

Conditions for Coverage of Home Health Services

208. CONDITIONS FOR COVERAGE FOR HOME HEALTH SERVICES UNDER BOTH HOSPITAL AND MEDICAL INSURANCE

208.1 Patient Must Be Under Care of a Physician.—Items and services must be furnished to an individual who is under the care of a physician. This physician may be the patient's private physician, or a physician on the staff of the home health agency, or a physician working under an arrangement with the institution which is the patient's residence, or, if the agency is hospital-based, a physician on the hospital or agency staff. The attending physician establishes the plan of treatment and also certifies to the necessity for home health services.

208.2 Services Furnished by Agency.—Items and services must be furnished by a participating home health agency or by others under arrangements made by the agency. (See § 200.2 for definition of "under arrangements.")

208.3 Services Furnished Under a Plan.—Items and services must be furnished under a plan established and periodically reviewed by a physician and which relates the items and services to the patient's condition. The plan must either be put into writing by the physician and made available to the home health agency which has accepted the patient as a client or the home health agency may make a written record of the physician's oral orders. In the latter situation, the agency forwards its written record to the physician who signs and returns the record to the agency. The date the agency puts the plan of treatment into writing should be recorded. For Part A home health benefits if the plan of treatment is established before July 1, 1981, it must be put into writing within 14 days of the patient's discharge from a qualifying inpatient stay (see § 210.2). For plans of treatment established on or after July 1, 1981, the prior inpatient stay requirement under Part A no longer applies, nor does the requirement that the plan of treatment be established within 14 days of discharge. Therefore, effective July 1, 1981, Part A as well as Part B plans must be put in writing prior to the submission of the bill. Home health services furnished before the plan is put into writing are covered if authorized by a physician. (See § 210.5 for coverage of Part A services rendered before the plan is put into writing where services are furnished prior to July 1,1981.) The plan must specify the types of services required and should, as far as possible, provide a long-range forecast of likely changes in the patient's condition. It should include the diagnosis and a description of the patient's functional limitation resulting from the illness or injury, the type and frequency of nursing services needed, drugs and medications, special diets, activities permitted, rehabilitation and therapy services, medical social services, home health aide services, and the medical supplies and appliances necessary.

The signature of the attending physician must be obtained on either a Part A or Part B plan prior to the submission of bills to the intermediary. The plan must be incorporated into the agency's permanent record for the patient. Any changes in the plan must be in writing and signed by the physician or, if given orally, reduced to writing and signed by a registered nurse or qualified therapist receiving such oral orders on behalf of the agency and countersigned by the physician as soon as practicable.

The plan must be reviewed by the attending physician in consultation with agency professional personnel at such intervals as the severity of the patient's illness requires but at least every 2 months. Each review of a patient's plan should contain the initials of the physician and show the date performed. The agency's record need not be forwarded to the intermediary for review but will be retained in the agency's file.

Prior to July 1, 1981, where an individual has coverage under both Part A and Part B, home health plans under both parts should not operate concurrently. (To have two plans operating concurrently would create administrative difficulties in counting home health visits, particularly if two home health agencies become involved.) For example, a plan of treatment is established after hospitalization for a condition for which the patient was hospitalized and the patient later requires home health services for a condition unrelated to the previous hospitalization but while the original plan of treatment is still in effect. The original plan of treatment should be modified to take into account the required home health services for the condition not related to previous institutionalization. However, at the point when none of the services being provided are needed because of the conditions for which the patient was confined, Part A benefits must be terminated since the physician certification requirements can no longer be met (see § 240.1), and Part B benefits may begin. Of course, if the patient does not have Part B coverage, the original plan of treatment cannot be modified to provide home health services not related to prior hospitalization.

When benefits under hospital insurance have been exhausted and a change to benefits under medical insurance is made, it is not necessary for the physician to change the plan of treatment.

After July 1, 1981, if a patient is eligible for home health services which are covered under both programs, payment is to be made under Part A.

If the patient does not receive at least one covered skilled nursing or physical or speech therapy visit or (effective July 1, 1981), an occupational therapy visit (see §§ 204, 205, 206) in a 60-day period, the home health plan is considered terminated for the purpose of Medicare reimbursement unless (1) the physician has reviewed the plan of treatment and made a recertification within the 60-day period which indicates that the lapse of visits is a part of the physician's regimen for the patient (see § 425), or (2) it is clear from the facts in the case that skilled nursing visits will be required at intervals less frequently than once every 60 days, but the intervals are predictable, e.g., it is predictable that services will be required only every 90 days, such as visits for the purpose of changing a silicone catheter. (See §§ 204.1 and 240.1.)

NOTE: Effective December 1, 1981, occupational therapy is eliminated as a basis for initial entitlement to home health services. However, a plan would not be terminated for the purpose of Medicare reimbursement for, the individual who no longer needs skilled nursing care on an intermittent basis or physical or speech therapy if such an individual receives at least one covered occupational therapy visit in a 60-day period.

208.4 Patient Confined to His Home.--In order for a beneficiary to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician certify in all cases that the beneficiary is confined to his home (see § 240.1). An individual does not have to be bedridden to be considered as confined to his home. However, the condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving their homes would require a considerable and taxing effort. If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration. It is expected that in most instances absences from the home which occur will be for the purpose of receiving medical treatment. However, occasional absences from the home for nonmedical purposes, e.g., an occasional trip to the barber.

a walk around the block or a drive, would not necessitate a finding that the individual is not homebound so long as the absences are undertaken on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home.

Generally speaking, a beneficiary will be considered to be homebound if he has a condition due to an illness or injury which restricts his ability to leave his place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person or if he has a condition which is such that leaving his home is medically contraindicated. Some examples of homebound patients which are also illustrative of the factors to be taken into account in determining whether a homebound condition exists would be: (1) a beneficiary paralyzed from a stroke who is confined to a wheelchair or who requires the aid of crutches in order to walk; (2) a beneficiary who is blind or senile and requires the assistance of another person in leaving his place of residence; (3) a beneficiary who has lost the use of his upper extremities and, therefore, is unable to open doors, use handrails on stairways, etc., and, therefore, requires the assistance of another individual in leaving his place of residence; (4) a patient who has just returned from a hospital stay involving surgery who may be suffering from resultant weakness and pain and, therefore, his actions may be restricted by his physician to certain specified and limited activities such as getting out of bed only for a specified period of time, walking stairs only once a day, etc.; and (5) a patient with arteriosclerotic heart disease of such severity that he must avoid all stress and physical activity, and (6) a patient with a psychiatric problem if his illness is manifested in part by a refusal to leave his home environment or is of such a nature that it would not be considered safe for him to leave his home unattended, even if he has no physical limitations.

The aged person who does not often travel from his home because of feebleness and insecurity brought on by advanced age would not be considered confined to his home for purposes of receiving home health services unless he meets one of the above conditions. A patient who requires speech therapy but does not require physical therapy or nursing services must also meet one of the above conditions in order to be considered as confined to his home. Thus, a person who has undergone a laryngectomy, yet is recovered to the point of being able to get about normally without undue effort, would not be considered as confined to his home.

Although a patient must be confined to his home to be eligible for covered home health services, some services cannot be provided at the patient's residence because equipment is required which cannot be made available there. If the services required by an individual involve the use of such equipment, the home health agency may make arrangements with a hospital, extended care facility, or a rehabilitation center to provide these services on an outpatient basis (see §§ 200.2 and 206.5). However, even in these situations, for the services to be covered as home health services the patient must be considered as confined to his home; and to receive such outpatient services it may be expected that a homebound patient will generally require the use of supportive devices, special transportation, or the assistance of another person to travel to the appropriate facility.

If for any reason a question is raised as to whether an individual is confined to his home, the agency will be requested to furnish the intermediary with the information necessary to establish that the beneficiary is homebound as defined above.

206.5 Patient's Place of Residence.—A patient's residence is wherever he makes his home. This may be his own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. However, an institution may not be considered a patient's residence if it:

(a) Meets at least the basic requirement in the definition of a hospital (§ 112.1), i.e., it is primarily engaged in providing by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or

(b) Meets at least the basic requirement in the definition of an extended care facility (§ 112.2), i.e., it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. If a patient is transferred from a participating extended care facility to a nonparticipating part of the facility which he uses as his home, the part will not be considered the patient's residence if it meets this requirement.

Thus, if an individual is a patient in an institution or distinct part of an institution which provides the services described in (a) or (b) above, he is not entitled to have payment made for home health services under either Part A or Part B since such an institution may not be considered his residence.

When a patient remains in a participating extended care facility following his discharge from active care, the facility may not be considered his residence for purposes of home health coverage.

210. SPECIAL CONDITIONS FOR COVERAGE OF HOME HEALTH SERVICES UNDER HOSPITAL INSURANCE (PART A)

In addition to the conditions listed in § 208, the following conditions must be met for coverage under hospital insurance for services furnished prior to July 1, 1981.

210.1 Effect of Spell of Illness on Coverage.—Prior to July 1, 1981, hospital insurance coverage extends only to home health visits (100 or less) furnished after the beginning of one spell of illness and before the beginning of the next. Effective July 1, 1981, the visit limitation is eliminated.

The controlling event is the beginning of the spell of illness. It is immaterial whether the patient is either in a spell of illness, or has ended a spell of illness and not begun a new one. A series of visits ends with the beginning of a new spell of illness. (See § 157.3 for the definition of a spell of illness and the examples in § 210.4 for the interrelationship of the spell of illness and the prior stay requirements for services furnished prior to July 1, 1981.)

For purpose of qualifying for posthospital home health benefits, a spell of illness begins with a stay in a hospital accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association even though the hospital does not participate in the Medicare program. This rule applies regardless of whether the hospital is within the United States or in a foreign country or whether the services are emergency or nonemergency. Effective July 1, 1981, the prior inpatient stay requirement is eliminated for coverage of home health services under Part A.

210.2 Prior Inpatient Stay.—In addition to the spell of illness requirement, the law specifies that the home health visits must take place in the year following the most recent discharge from a covered SNF stay of any duration or from a medically necessary stay of at least 3 consecutive days in: (1) a participating general, psychiatric or tuberculosis hospital or (2) a participating distinct part of a psychiatric or tuberculosis hospital, or (3) a nonparticipating general, psychiatric, or tuberculosis hospital which meets at least the conditions of participation for a hospital described in § 157.1E and G, i.e., an emergency services hospital. (For discharges on or before December 31, 1967, such a hospital had to meet all the requirements of § 157.1, except F, H, and I.) A nonparticipating psychiatric or tuberculosis hospital need not meet the special requirements applicable to psychiatric and tuberculosis hospitals. Federal hospitals need not be licensed under State or local licensing laws to meet the prior stay hospital definition. Stays in Christian Science Sanatoriums are excluded for the purpose of satisfying the prior inpatient stay requirement.

The 3 consecutive calendar days requirement can be met by stays totalling 3 consecutive days in one or more hospitals. In determining whether the requirement has been met, the day of admission, but not the day of discharge, is counted as a hospital inpatient day. There must be an actual discharge of the patient from the hospital or skilled nursing facility to his residence. See § 208.5 for conditions under which an institution may not be considered the patient's residence.

Effective July 1, 1981, the prior inpatient stay requirement is eliminated for coverage of home health services.

The discharge from the hospital which is required to qualify home health services payment under hospital insurance must have occurred on or after the first day of the month in which the patient attained age 65 or became entitled to Health Insurance benefits under the disability or chronic renal disease provisions of the law.

210.3 **Three-Day Prior Hospitalization—Foreign Hospital.**—A stay of 3 or more days in a hospital outside the United States may satisfy the prior inpatient stay requirement for posthospital home health services within the United States if the foreign hospital is qualified as an "emergency hospital." If a stay of 3 or more days in a hospital outside the United States is being considered to satisfy the prior inpatient stay requirement, the home health agency must submit documentation to the intermediary. This evidence can be either: (1) an itemized bill or hospital form prepared by the foreign hospital showing dates of admission and discharge and a description of the illness or injury treated (obtained from the beneficiary); or (2) a medical report prepared by the foreign hospital and sent to the patient's U.S. physician showing dates of admission and discharge and a description of the illness or injury treated (obtained from the physician).

If neither type of evidence can be obtained, secure whatever information is available. Such evidence or information should be attached to the start of care notice sent to the intermediary.

The intermediary will advise the agency whether the prior inpatient stay requirement is met and whether Part A benefits are payable. Effective July 1, 1981, the prior inpatient stay requirement is eliminated for coverage of home health services.

210.4 **Interrelationship of Spell of Illness and Prior Inpatient Stay.**—Ordinarily, the spell of illness and prior inpatient stay requirements for services furnished prior to July 1, 1981, will be met by the same 3-day stay in a participating hospital. However, there are special situations where multiple inpatient stays combine to satisfy both requirements.

EXAMPLE 1: A covered 1-day hospital stay began a spell of illness but did not satisfy the prior stay requirement. A subsequent noncovered stay of at least 3 days' duration in a nonparticipating hospital described above could satisfy the prior inpatient stay requirement even though it would not start a spell of illness unless the hospital is accredited by the JCAH or AOA. The 3-day stay may occur, for example, within 60 days after the 1-day hospital stay, i.e., during the spell of illness, or more than 60 days after the 1-day hospital stay, i.e., after the spell of illness ends.

EXAMPLE 2: A noncovered 3-day hospital stay in a nonparticipating non-accredited hospital described in Example 1 above, satisfies the prior stay requirement. A subsequent 1-day stay in a participating hospital starts the spell of illness.

See § 210.5 for time limit on plan establishment following discharge from prior stay.

The following are examples of situations where a single inpatient stay satisfies both requirements.

EXAMPLE 3: A noncovered 3-day hospital stay in a nonparticipating nonaccredited hospital described in Example 1 above, is followed within 14 days by a 1-day covered skilled nursing facility stay. In this case, the 3-day hospital stay satisfies the prior stay requirement for coverage of the SNF stay (§ 155.3). The 1-day SNF stay begins the spell of illness and satisfies the prior stay requirement for subsequent home health services.

EXAMPLE 4: A noncovered 3-day stay in an accredited but nonparticipating hospital (§ 157.3) satisfies both the spell of illness and prior stay requirements.

See additional examples in § 215.3 for services furnished prior to July 1, 1981.

210.5 Fourteen-Day Limit on Plan Establishment.—For services furnished prior to July 1, 1981, the plan for home health services (§ 208.3) must be established within 14 days after the patient's discharge from the qualifying prior inpatient stay. In determining the 14-day period, the day of discharge is not counted in the 14 days. For example, a patient's plan is established within 14 days if he was discharged from a hospital on August 1 and his plan was established on August 15.

There is no limitation on when a plan may be established before the patient's release from the institution. In fact, it is reasonable to expect that a physician may wish to establish a plan of treatment for home health care before the patient has been released from the institution in order to assure that needed services would be immediately available to the patient. However, it is unlikely that such a plan would be established before the physician has determined the patient's approximate release date from the hospital or extended care facility since it would be difficult to determine prior to that time just what services will be required in the treatment of the individual's illness or injury upon his discharge to the home setting.

In some cases, services are furnished after discharge from the hospital or extended care facility and before the plan has been reduced to writing. Payment under Part A may be made for such services if authorized by a physician, provided the plan is reduced to writing within 14 days of the patient's discharge. (Effective July 1, 1981, a plan does not have to be established within 14 days of discharge since the prior inpatient stay requirement is eliminated.)

210.6 Related Illness or Impairment.—In order for home health services to be covered under hospital insurance, a doctor must certify that the patient needs intermittent nursing care or physical or speech therapy for any condition for which he was receiving inpatient hospital or extended care services. Effective July 1, 1981, no such related condition shall be required for covered home health services under hospital insurance.

210.7 Transfer of Patient.—If it becomes necessary for the inpatient to transfer to a different physician or home health agency (in a different locality) after the timely establishment of the required physician's plan, the original plan may be continued in the new locality if:

A. There is a referral by the patient's physician in the old locality of both the patient and the plan to a physician in the new locality.

B. The patient's physician in the new locality accepts the original plan of treatment and assumes the responsibility of conducting the required periodic review of the plan. The plan could be modified from time to time as determined necessary by the patient's physician in the new locality.

C. A participating home health agency in the new locality accepts the patient.

For services furnished prior to July 1, 1981, the number of posthospital home health visits already used in the old locality in the (applicable) year would be taken into account in determining when the limit of 100 visits under the hospital plan is reached. Effective July 1, 1981, the 100 visit limitation is eliminated.

EXAMPLE: A health insurance beneficiary has received 40 home health visits under Part A when it is decided that his overall recovery would be hastened if he moved to a relative's home in a city 100 miles away. However, the physician who established and is reviewing his home health plan recommends that the physical therapy treatments he has been receiving be continued. A physician in the distant city concurs and agrees to take responsibility for continuance of the plan. When the patient moves, the plan is submitted to a home health agency in that city and services continue as before. The patient is entitled to the remaining 60 home health visits in the applicable year under Part A at his new residence.

Special Conditions for Coverage of Part B

212. SPECIAL CONDITIONS FOR COVERAGE OF HOME HEALTH SERVICES UNDER SUPPLEMENTARY MEDICAL INSURANCE (PART B)

212.1 Noneligibility under Hospital Insurance.—For home health services to be covered under supplementary medical insurance, the patient must be currently enrolled in the medical insurance plan and where the home health services to be provided are covered under hospital insurance, not be eligible to receive such services under hospital insurance. Where a patient is eligible for home health services which are covered under both programs, the services are chargeable under hospital insurance. When the benefits payable under hospital insurance are exhausted, he may then utilize the benefits available under the supplementary medical insurance program. Effective July 1, 1981, the 100 visit limitation is eliminated and services continue to be covered under hospital insurance (Part A). A plan covering services under the medical insurance program must be established by the physician and must be reduced to writing before the agency bills for the services.

Prior inpatient care in a hospital or skilled nursing facility is not required for coverage of home health services under the supplementary medical insurance plan.

212.2 Change to Medical Insurance Home Health Services on Change of Residence.—A patient who changes residence before exhausting his 100 home health visits under hospital insurance can receive further home health services only under the medical insurance program if there is no further eligibility for home health services under the hospital insurance plan. This might occur, for example, in the following situations:

A. The physician in the old locality terminates the posthospital home health plan, or

B. There is no physician in the new locality who agrees to accept both the patient and the plan, e.g., the new physician wants to establish an entirely new plan.

For coverage under medical insurance in these circumstances, the new physician must establish a new plan.

See § 210.7 for conditions under which home health services under hospital insurance may continue in the new locality.

NOTE: Effective July 1, 1981, the 100 visit limitation is eliminated.

215. DURATION OF HOME HEALTH SERVICES

215.1 Duration of Home Health Services Under Hospital Insurance.—Under hospital insurance, prior to July 1, 1981, the patient is entitled to up to 100 visits in the 1-year period after the most recent discharge from a qualifying inpatient stay (§ 210.2) and before a new benefit period begins (§ 210.1). There are no deductible or coinsurance requirements for these services.

If before a series of home health visits is completed, a patient receives inpatient services which start a new benefit period, the series of visits is terminated. Both the "prior inpatient stay" (§ 210.2) and "timely establishment of plan" (§ 210.5) requirements must be met in the new benefit period to provide coverage for a new series of home health visits.

If, during the same benefit period, the home health patient returns to a hospital or skilled nursing facility for a stay which meets the prior stay requirement, a new 1-year period for his Part A visits is established dating from his latest discharge. The total number of visits available before the next benefit period begins remains unchanged.

In rare cases, a home health patient may return to a hospital for a stay which satisfies the prior-stay requirement but does not begin a new benefit period, i.e., a 3-day noncovered stay in a nonparticipating hospital which meets all the conditions of participation of § 157.1. In this situation, a new 1-year period begins with the discharge and the number of visits remains unchanged. However, if the patient returns to a nonparticipating hospital which is JCAH or AOA accredited, such stay begins a new benefit period (See § 157.3).

The end of the year for hospital insurance purposes is determined as follows: Count 365 days (366 when February 29 is included) beginning with the later of the following:

A. The date of discharge from a 3-day stay in any hospital, or

B. The date of discharge after December 31, 1966, from an extended care facility stay for which posthospital extended care benefits were payable on the patient's behalf.

Effective July 1, 1981, the 100 visit limitation under Part A and Part B, and the prior inpatient stay and the spell of illness requirements under Part A are eliminated.

215.2 Duration of Home Health Services Under Supplementary Medical Insurance.— Under supplementary medical insurance a patient is entitled to 100 visits in a calendar year. Entitlement to visits under supplementary medical insurance is related to the calendar year and is unaffected by the patient's spell(s) of illness. Effective July 1, 1981, the 100 visit limitation is eliminated. If entitled to services under both hospital insurance and supplementary medical insurance, the visits must first be charged against the hospital insurance.

The end of the year under medical insurance is December 31.

215.3 Examples of Duration of Services Under Hospital and Medical Insurance.

EXAMPLE 1: Jones is hospitalized on February 10 and discharged on March 15, 1967; he has no other hospital or skilled nursing facility stay in 1967 or 1968. He has 100 home health visits beginning the latter part of March and ending on February 20, 1968. All 100 visits are paid for under hospital insurance since the 1-year period runs from March 15, 1967, the date of the hospital discharge, to March 14, 1968. Although Jones' spell of illness ended on May 13, 1967, the end of the 60-day period beginning with the day of the hospital discharge, home health eligibility was unaffected since a new spell of illness did not begin subsequently.

EXAMPLE 2: Robinson was an inpatient in a hospital four times during the same spell of illness, i.e., there was no period of 60 consecutive days during which he was not hospitalized. He was discharged from the hospital, which meets the requirements to qualify subsequent home health services for payment under hospital insurance, on March 15, 1967, May 13, 1967, July 12, 1967, and September 9, 1967. Each hospital stay was for at least 3 consecutive days except the last one. He had home health visit beginning with May 23, 1967, based on a plan established after his hospital discharge of May 13. The 1-year period for home health services under hospital insurance began May 13, 1967, the date of his most recent discharge (in relation to the first home health visit in the spell of illness) from a hospital after a stay of 3 days; it can end no later than July 12, 1968, 1 year after the latest discharge from a hospital stay of at least 3 consecutive days. Thus, in some situations, the "1-year period" during which an individual may have up to 100 home health visits may in fact exceed a year overall.

EXAMPLE 3: Smith is hospitalized on February 10 and discharged on March 15. He reenters the hospital on July 4. He had 30 home health visits between March 15 and July 4. Since he had been out of the hospital for more than 60 days after his discharge on March 15, a new spell of illness began on July 4, when he reentered the hospital. Therefore, he is not entitled to any additional home health visits under hospital insurance based on his February-March hospital stay. However, an additional 100 home health visits under hosptal insurance may begin based on his hospitalization beginning July 4, if he is confined for at least 3 days. If it is for less than 3 days, he will not qualify for home health visits under hospital insurance in the new spell of illness. However, if he is enrolled in the supplementary medical insurance program he is entitled to an additional 100 visits under Part B through December 31, subject to the deductible provisions.

EXAMPLE 4: Brown is discharged from a hospital on February 15, 1967, after a 3-day stay. He begins receiving home health visits on February 18, 1967. He has until February 14, 1968, to use his 100 visits under hospital insurance. In July, however, he receives his 100th visit, exhausting the number of visits to which he is entitled under hospital insurance. Coverage of his home health visits may continue unbroken, if he is enrolled under supplementary medical insurance. In that event, he may receive an additional 100 visits under medical insurance through December. In January 1968, he becomes entitled to an additional 100 visits under supplementary medical insurance for the calendar year of 1968.

NOTE: The Omnibus Reconciliation Act of 1980 eliminates the prior inpatient stay requirement under Part A, the visit limitation under Part A and Part B, and the Part B deductible. Therefore, the above examples pertain only to home health services furnished prior to July 1, 1981.

218. COUNTING VISITS UNDER THE HOSPITAL AND MEDICAL PLANS

The number of visits are counted in the same manner under both the hospital plan and medical plan.

218.1 Visit Defined.—A visit is a personal contact in the place of residence of a patient made for the purpose of providing a covered service by a health worker on the staff of the home health agency or by others under contract or arrangement with the home health agency; or a visit by a patient on an outpatient basis to a hospital, extended care facility, or rehabilitation center, or outpatient department affiliated with a medical school when arrangements have been made by the home health agency for one or more of the covered services. (See S 200.2 - 203.)

218.2 Counting Visits.—If a visit is made simultaneously by two or more persons from the home health agency to provide a single service, for which one person supervises or instructs the other, it is counted as one visit (see example 1). If one person visits the patient's home more than once during a day to provide services, each visit is recorded as a separate visit (see example 2). If a visit is made by two or more persons from the home health agency for the purpose of providing separate and distinct types of services, each is recorded—i.e., two or more visits (see example 3). If the patient is taken elsewhere for the service because the service could not be furnished in his residence, one visit is counted for each service he receives (see example 4).

Example 1. If an occupational therapist and an occupational therapy assistant visit the patient together to provide therapy and the therapist is there to supervise the assistant, one visit is counted.

Example 2. If a nurse visits the patient in the morning to dress a wound and later must return to replace a catheter, two visits are counted.

Example 3. If the therapist visits the patient for treatment in the morning and the patient is later visited by the assistant for additional treatment, two visits are counted.

Example 4. If an individual is taken to a hospital to receive outpatient therapy that could not be furnished in his own home (e.g., hydrotherapy) and, while at the hospital receives speech therapy and other services, two or more visits would be charged.

Example 5. Many home health agencies provide home health aide services on an hourly basis (ranging from 1 to 8 hours a day). However, in order to allocate visits properly against a patient's maximum allowable visits, home health aide services are to be counted in terms of visits. Thus, regardless of the number of continuous hours a home health aide spends in a patient's home on any given day, one "visit" is counted for each such day. If, in a rare situation, a home health aide visits a patient for an hour or two in the morning, and again for an hour or two in the afternoon, two visits are counted.

Under both hospital insurance and supplementary medical insurance, visits count toward the 100-visit maximums only if payment was made for the visits by the program or, if payment would be made if requested by the patient, and the certification requirements (see §§ 240ff.) were met. Visits by personnel other than those providing covered services are not counted. Salaries of personnel employed by the agency to assist in overall operation of the program (e.g., a nutritionist) may be taken into consideration in computing overhead costs of the agency when claiming reimbursement.

An important item to remember about visits under supplementary medical insurance is that visits provided a patient during the period in which he or she is incurring sufficient expenses to satisfy the deductible will count toward the 100-visit maximum, even though reimbursement is not possible because the cash deductible has not been satisfied.

The above discussion which relates to the visit limitation and deductible requirement pertains to services furnished prior to July 1, 1981.

218.3 Evaluation Visits.--Home health agencies are required by regulations to have written policies concerning the acceptance of patients by the agency. These include consideration of the physical facilities available in the patient's place of residence, the homebound status, and the attitudes of family members for the purpose of evaluating the feasibility of meeting the patient's medical needs in the home health setting. When personnel of the agency make such an initial evaluation visit, the cost of the visit is considered an administrative cost of the agency and is not chargeable as a visit since at this point the patient has not been accepted for care. If, however, during the course of this initial evaluation visit, the patient is determined suitable for home health care by the agency, and is also furnished the first skilled service as ordered under the physician's plan of treatment, the visit would become the first billable visit.

An observation and evaluation (or reevaluation) visit made by a nurse (see § 204.4 for a further discussion of skilled nursing observation and evaluation visits) or other appropriate personnel, ordered by the physician for the purpose of evaluating the patient's condition and his or her continuing need for skilled services would be covered as a skilled visit.

A supervisory visit made by a nurse or other appropriate personnel (as required by the conditions of participation) to evaluate the specific personal care needs of the patient or to review the manner in which the personal care needs of the patient are being met by the aide is considered an administrative function and is not chargeable to the patient as a skilled visit.

219. MEDICAL AND OTHER HEALTH SERVICES.

The voluntary medical insurance plan is designed to supplement the basic hospital insurance coverage. In addition to providing coverage for 100 home health visits in a calendar year (§ 215.2), the medical insurance plan provides coverage for certain "medical and other health services." Reimbursement may be made to a home health agency which furnishes either directly or underarrangements with others the following "medical and other health services" to beneficiaries with Part B coverage who have exhausted their Part A or Part B home health benefits or are not entitled to such as well as any other Part B benefits. Effective July 1, 1981, the 100 visit limitation under Part A and Part B is eliminated.

1. Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations. (See § 219.1.)

2. Prosthetic devices. (See § 219.2.)

3. Leg, arm, back, and neck braces, trusses, and artifical legs, arms and eyes. (See § 219.3.)

4. Outpatient physical therapy services and effective January 1, 1973, outpatient speech pathology services. (See § 219.4.)

5. Rental and purchase of durable medical equipment. (See § 220ff.)

6. Ambulance service. (See § 221.)

7. Hepatitis B Vaccine.—Vaccinations or inoculations are excluded from coverage as "immunizations" unless they are directly related to the treatment of an injury or direct exposure to a disease or condition. An exception was made in 1980 to include coverage of pneumococcal pneumonia vaccinations.

With the enactment of the Deficit Reduction Act of 1984 (P.L. 98-369), coverage under Part B is extended to hepatitis B vaccine and its administration, furnished to a Medicare beneficiary who is at high or intermediate risk of contracting hepatitis B. This coverage is effective for services furnished on or after September 1, 1984.

High-risk groups currently identified include:

End-Stage Renal Disease (ESRD) patients;
Hemophiliacs who receive Factor VIII or IX concentrates;
Clients of institutions for the mentally retarded;
Persons who live in the same household as an Hepatitis B Virus (HBV) carrier;
Homosexual men;
Illicit injectable drug abusers.

Intermediate risk groups currently identified include:

Staff in institutions for the mentally retarded;
Workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work.

Exception:

Persons in the above-listed groups would not be considered at high or intermediate risk of contracting hepatitis B, however, if there is laboratory evidence positive for antibodies to hepatitis B. (ESRD patients are routinely tested for hepatitis B antibodies as part of their continuing monitoring and therapy.)

For Medicare program purposes, the vaccine may be administered—upon the order of a doctor of medicine or osteopathy—by home health agencies, skilled nursing facilities, ESRD facilities, hospital outpatient departments, persons recognized under the "incident to physicians' services" provision of the law, and, of course, doctors of medicine and osteopathy.

A charge separate from the ESRD composite rate will be recognized and paid for administration of the vaccine to ESRD patients.

8. Hemophilia Clotting Factors.— Blood clotting factors, for hemophilia patients competent to use such factors to control bleeding without medical or other supervision, and items related to the administration of such factors are covered under Part B. Coverage is effective for such items and services purchased on or after July 18, 1984. Prior to the enactment of the Deficit Reduction Act of 1984 (P.L. 98-369), all drugs and biologicals which were of the type that could be self-administered were excluded from coverage. The coverage of blood clotting factors is an exception to the exclusion.

The amount of clotting factors determined to be necessary to have on hand and thus covered under this provision will be based on the historical utilization pattern or profile developed by the carrier for each patient. It is expected that the treating source; e.g., a family physician or Comprehensive Hemophilia Diagnostic and Treatment Center, will have such information. From this data, the contractor should be able to make reasonable projections concerning the quantity of clotting factors anticipated to be needed by the patient over a specific period of time. Unanticipated occurrences involving extraordinary events, such as automobile accidents, inpatient hospital stays, etc., will change this base line data and should be appropriately considered. In addition, changes in a patient's medical needs over a period of time will require adjustments in the profile.

See § 222 for a discussion of the special option available to patients under a home health plan who require physical therapy or speech pathology (therapy) services, or the use of medical appliances.

219.1 Surgical Dressings, and Splints, Casts, and Other Dressings Used for Reduction of Fractures and Dislocations.--Surgical dressings are limited to primary dressings, i.e., therapeutic and protective coverings applied directly to lesions either on the skin or opening to the skin required as the result of a surgical procedure performed by a physician. (Items such as ace bandages, elastic stockings, support hose, Spenco boots and other foot coverings, leotards, knee supports, surgical leggings, gauntlets and pressure garments for the arms and hands are generally used as secondary coverings and therefore would not be covered as surgical dressings.) Surgical dressings are usually applied first by a physician but may be reapplied by others including the patient or a member of his family. Dressings required for purposes other than a surgical lesion, e.g., bedsores, are not covered. Splints and casts, etc., include dental splints.

Prior to October 30, 1972, a colostomy bag and necessary accoutrements required for its attachment were covered as a surgical dressing, but irrigation equipment and supplies used in treating a colostomy patient were not. (See § 219.2 below for statement regarding coverage of such items as prosthetic devices effective October 30, 1972.)

219.2 Prosthetic Devices.—Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ and replacements or repairs of such devices are covered when furnished incident to physicians' services or on a physician's orders.

Effective for items furnished on or after October 30, 1972, colostomy (and other ostomy) bags and necessary accoutrements required for attachment are covered as prosthetic devices. This coverage also includes irrigation and flushing equipment and other items

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and supplies directly related to ostomy care whether or not the attachment of a bag is required. See § 219.1 for discussion of such items as surgical dressings prior to October 30, 1972.

Examples of prosthetic devices include cardiac pacemakers, hemodialysis equipment (see § 220.1B1), prosthetic lenses, breast prostheses (including a surgical brassiere) for postmastectomy patients, maxillofacial devices and devices which replace all or part of the function of the ear or nose. A urinary collection and retention system with or without a tube would be a prosthetic device replacing bladder function in cases of permanent urinary incontinence. The Foley catheter would also be considered a prosthetic device when ordered for a patient with permanent urinary incontinence. However, chux, diapers, rubber sheets, etc., are not covered under this provision since they do not perform the collecting and retention function of the bladder.

219.3 Leg, Arm, Back, and Neck Braces, Trusses, and Artificial Legs, Arms, and Eyes.--These appliances are covered under Part B when furnished incident to physicians' services or on a physician's order. A brace includes rigid and semi-rigid devices which are used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. Elastic stockings, garter belts, and similar devices do not come within the scope of the definition of a brace. Back braces include, but are not limited to, special corsets, sacroiliac, sacrolumbar, dorsolumbar corsets and belts. A terminal device (e.g., hand or hook) is covered under this provision whether or not an artificial limb is required by the patient.

Stump stockings and harnesses (including replacements) are also covered when these appliances are essential to the effective use of the artificial limb.

Adjustments to an artificial limb or other appliance required by wear or by a change in the patient's condition are covered when ordered by a physician. To the extent applicable the provisions relating to the repair and replacement of durable medical equipment in § 220.4 should be followed with respect to the repair and replacement of artificial limbs, braces, etc. Adjustments, repairs, and replacement are covered even when the item had been in use before the user enrolled in Part B of the program so long as the device continues to be medically required.

219.4 Outpatient Physical Therapy and Speech Pathology Services.—Physical therapy and speech pathology services provided to outpatients by a participating hospital, skilled nursing facility, home health agency, clinic, rehabilitation agency or public health agency or by others under arrangements with and under the supervision of such an institution or agency are covered as "medical and other health services" under Part B of the program. Coverage of outpatient physicial therapy services was effective July 1, 1968, and outpatient speech pathology services were covered effective January 1, 1973. (NOTE: An individual is not required to be homebound to be eligible for these benefits.)

To be reimbursable under the "medical and other health services" provision, outpatient physical therapy or speech pathology services must meet all of the following conditions. In addition, outpatient physical therapy services must meet all of the conditions set forth in § 205.1.

See § 222 for a discussion of the special option which permits a patient under a home health plan to receive physical therapy or speech pathology services as "medical and other health services" rather than as home health services. Effective July 1, 1981, it will not be to the patient's advantage to receive the physical therapy or speech pathology services he or she needs as a "medical or other health services" since unlimited visits will be available under Part A and Part B.

A. Content of the Physician's Certification.—No payment may be made for outpatient physical therapy or speech pathology services unless a physician certifies that:

1. the outpatient physical therapy or speech pathology services are or were furnished while the patient was under the care of a physician (see D below);

2. a plan for furnishing such services is or was established and periodically reviewed by the physician. Effective January 1, 1981, a plan of treatment for outpatient speech pathology services may be established either by the physician or the speech pathologist providing such services. Effective July 18, 1984, a plan of treatment for outpatient physical therapy services may be established by either the physician or the qualified physical therapist providing such services. However, the plan must be periodically reviewed by the physician. (See E below);

3. the services are or were required by the patient.

Since the certification is closely associated with the plan of treatment, the same physician who establishes the plan (or effective January 1, 1981, in the case of outpatient speech pathology services the same physician who reviews the plan established by the speech pathologist providing such services, or effective July 18, 1984, in the case of outpatient physical therapy, the same physician who reviews the plan established by the qualified physical therapist providing such services) must certify to the necessity for outpatient physical therapy or speech pathology services. Certification should be obtained at the time the plan of treatment is established or as soon thereafter as possible. "Physician" means a doctor of medicine, osteopathy (including an osteopathic practitioner), or podiatric medicine legally authorized to practice by the State in which he performs the services. In addition, physician certification by doctors of podiatric medicine must be consistent with (1) the scope of the professional services provided by a doctor of podiatric medicine as authorized by applicable State law and (2) the policy of the agency with respect to which the services are performed.

B. Recertification.—When outpatient physical therapy or speech pathology services are continued under the same plan of treatment for a period of time, the physician must recertify at intervals of at least once every 30 days that there is a continuing need for such services and should estimate how long services will be needed. The recertification should be obtained at the time the plan of treatment is reviewed since the same interval (at least once every 30 days) is required for the review of the plan. Recertifications must be signed by the physician who reviews the plan of treatment. The form of the recertification and the manner of obtaining timely recertification is up to the individual home health agency.

For information regarding the method and disposition of certifications, refer to S 240.2 and for delayed certification refer to S 240.4.

C. Outpatient.—Outpatient physical therapy and speech pathology services are reimbursable when furnished by a provider to its outpatients, i.e., to patients in their homes, to patients who come to the facility's outpatient department, or to inpatients of other institutions. In addition, coverage includes physical therapy and speech pathology services furnished by participating hospitals and skilled nursing facilities to those of their inpatients who have exhausted their Part A inpatient benefits or who are otherwise not eligible for Part A benefits. Providers of outpatient physical therapy and speech pathology services that have inpatient facilities, other than participating hospitals and skilled nursing facilities, may not furnish covered outpatient physical therapy or speech pathology services to their own inpatients. However, since the inpatients of one institution may be considered the outpatients of another institution, all providers of outpatient physical therapy and speech pathology services may furnish such services to inpatients of another health facility.

While outpatient physical therapy and speech pathology services are payable when furnished in the home, when added expense is caused by a visit to the home, a question must be raised as to whether the rendition of the service in the home is reasonable and necessary. Where the patient is not confined to his home, such added expense cannot be considered as reasonable and necessary for the treatment of an illness or injury since the home visit is more costly than the medically appropriate and realistically feasible alternative pattern of care; e.g., in the facility's outpatient department. Consequently, these additional expenses incurred by providers due to travel to a person who is not homebound are not covered.

D. Outpatient Must Be Under the Care of a Physician.—Outpatient physical therapy or speech pathology services must be furnished to an individual under the care of a physician. There must be evidence in the patient's clinical record that a physician has seen him at least every 30 days. If the record does not reflect this, the provider is responsible for contacting the physician to determine whether this requirement is met. The physician may be the patient's private physician, a physician on the staff of the provider, a physician associated with an institution which is the patient's residence, or a physician associated with a medical facility in which the patient is an inpatient. The attending physician establishes the plan of treatment and also makes the necessary certifications. Effective January 1, 1981, a plan of treatment for outpatient speech pathology services may be established by either the physician or the speech pathologist providing such services. Effective July 18, 1984, a plan of treatment for outpatient physical therapy services may be established by either the physician or the qualified physical therapist providing such services. However, the physician still must make the necessary certifications. See A and B above and E following.)

E. Outpatient Physical Therapy or Outpatient Speech Pathology Services Furnished Under a Plan.—Prior to July 18, 1984 outpatient physical therapy or prior to January 1, 1981, speech pathology services must be furnished under a written plan established and periodically reviewed by the attending physician after any necessary consultation with the physical therapist or speech pathologist, as appropriate. The plan must be established (that is, reduced to writing either by the physician who makes the plan available to the provider or by the agency itself when it makes a written record of the physician's oral orders) before treatment is begun. The plan should be promptly signed by the ordering physician and incorporated into the agency's permanent record for the patient.

The plan must relate the type, amount, frequency, and duration of the physical therapy or speech pathology services that are to be furnished and indicate the diagnosis and anticipated goals. Any changes to this plan must be in writing and signed by the physician. Changes to the plan may also be made pursuant to the oral orders given by the attending physician to a qualified physical therapist (in the case of physical therapy), a qualified speech pathologist (in the case of speech pathology) a registered professional nurse, or physician on the staff of the home health agency. Such changes must be immediately recorded in the patient's records and signed by the individual receiving the orders.

Effective January 1, 1981, for outpatient speech pathology services and effective July 18, 1984 for outpatient physical therapy services, such services also may be furnished under a written plan of treatment established by the speech pathologist providing such speech pathology services or by the qualified physical therapist providing such physical therapy services; however, the plan must be periodically reviewed by the physician. The speech pathologist's or physical therapist's plan must be established (that is, reduced to writing by that pathologist or physical therapist or by the provider itself when it makes a written record of the pathologist's or physical therapist's oral orders) before treatment is begun. Such plans should be promptly signed by the pathologist or physical therapist providing such services and incorporated into the provider's permanent record for the patient. Plans of treatment for outpatient speech pathology or outpatient physical therapy services established by the speech pathologist or physical therapist providing such services must also relate the type, amount, frequency, and duration of the speech pathology or physical therapy services that are to be furnished the patient and indicate the diagnosis and anticipated goals. Any changes to a plan established by the speech pathologist or physical therapist must be made in writing and signed by that pathologist or physical therapist or by the attending physician. Changes to such plans may be made pursuant to the oral orders given by the attending physician, as stated above, or by the pathologist to another qualified speech pathologist or by the physical therapist to another qualified physical therapist or a registered professional nurse on the staff of the provider. Such changes must be immediately recorded in the patient's records and signed by the individual receiving the orders. While the physician may change a plan of treatment established by the speech pathologist or physical therapist providing such services, the speech pathologist or physical therapist may not alter a plan of treatment established by a physician.

The plan must be reviewed by the attending physician, in consultation with the HHA's physical therapist(s) or speech pathologist(s) at such intervals as the severity of the patient's condition requires, but at least every 30 days. Each review of the plan should contain the initials of the physician and the date performed. The patient's plan normally need not be forwarded to the intermediary for review but will be retained in the agency's file. The HHA must certify on the billing form that the plan is on file (see § 401ff.).

NOTE: Although the 1972 amendments provide coverage of a limited amount of physical therapy services furnished a patient by a physical therapist as an independent practitioner they do not provide coverage of any speech pathology services furnished by a speech pathologist as an independent practitioner.

220 RENTAL AND PURCHASE OF DURABLE MEDICAL EQUIPMENT

A participating provider of service may be reimbursed under Part B on a reasonable cost basis for durable medical equipment which it rents or sells to a beneficiary for use in his home if the following three requirements are met:

A. The equipment meets the definition of durable medical equipment (§ 220.1); and

B. The equipment is necessary and reasonable for the treatment of the patient's illness or injury or to improve the functioning of his malformed body member (§ 220.2); and

C. The equipment is used in the patient's home (§ 220.3).

Payment may also be made under this provision for repairs, maintenance, and delivery of equipment as well as for expendable and nonreusable items essential to the effective use of the equipment subject to the conditions in § 220.4.

See § 222 for a discussion of the special option available to patients under a home health plan who require the use of medical appliances.

220.1 Definition of Durable Medical Equipment.—For purposes of coverage under Part B, durable medical equipment is equipment which (1) can withstand repeated use, and (2) is primarily and customarily used to serve a medical purpose, and (3) generally is not useful to a person in the absence of illness or injury, and (4) is appropriate for use in the home. All requirements of the definition must be met before an item can be considered to be durable medical equipment.

~~of illness or injury, and (4) is appropriate for use in the home. All requirements of the definition must be met before an item can be considered to be durable medical equipment.~~

A. Durability.--An item is considered durable if it can withstand repeated use; i.e., the type of item which could normally be rented. Medical supplies of an expendable nature such as incontinent pads, lambs wool pads, catheters, ace bandages, elastic stockings, surgical face masks, irrigating kits, sheets, and bags are not considered "durable" within the meaning of the definition. There are other items which, although durable in nature, may fall into other coverage categories such as braces, prosthetic devices, artificial arms, legs, and eyes.

B. Medical Equipment.--Medical equipment is equipment which is primarily and customarily used for medical purposes and is not generally useful in the absence of illness or injury. In most instances, no development will be needed to determine whether a specific item of equipment is medical in nature. However, some cases will require development to determine whether the item constitutes medical equipment. This development would include the advice of local medical organizations (providers, medical schools, medical societies) and specialists in the field of physical medicine, and rehabilitation. If the equipment is new on the market, it may be necessary, prior to seeking professional advice, to obtain information from the supplier or manufacturer explaining the design, purpose, effectiveness, and method of using the equipment in the home as well as the results of any tests or clinical studies that have been conducted.

1. Equipment Presumptively Medical.--Items such as hospital beds, wheelchairs, hemodialysis equipment, iron lungs, respirators, intermittent positive pressure breathing machines, medical regulators, oxygen tents, crutches, canes, trapeze bars, walkers, inhalators, nebulizers, commodes, suction machines, and traction equipment presumptively constitute medical equipment. (Although hemodialysis equipment is a prosthetic device it also meets the definition of durable medical equipment, and reimbursement for the rental or purchase of such equipment for use in the beneficiary's home will be made only under the provisions for payment applicable to durable medical equipment.)

2. Equipment Presumptively Nonmedical.--Equipment which is primarily and customarily used for a nonmedical purpose may not be considered "medical" equipment for which payment can be made under the medical insurance program. This is true even though the item has some remote medically related use. For example, in the case of a cardiac patient, an air conditioner might possibly be used to lower room temperature to reduce fluid loss in the patient and to restore an environment conducive to maintenance of the proper fluid balance. Nevertheless, because the primary and customary use of an air conditioner is a nonmedical one, the air conditioner cannot be deemed to be medical equipment for which payment can be made.

Other devices and equipment used for environmental control or to enhance the environmental setting in which the beneficiary is placed are not considered covered durable medical equipment. These include, for example, room heaters, humidifiers, dehumidifiers, and electric air cleaners. Equipment which basically serves comfort or convenience functions or is primarily for the convenience of a person caring for the patient, such as elevators, stairway elevators, posture chairs, and cushion lift chairs do not consitute medical equipment. Similarly, physical fitness equipment, e.g., an exercycle; first-aid or precautionary-type equipment, e.g., preset portable oxygen units; self-help devices; e.g., safety grab bars; and training equipment, e.g., speech teaching machines and braille training texts, are considered nonmedical in nature.

3. Special Exception Items.--Specified items of equipment may be covered under certain conditions even though they do not meet the definition of durable medical equipment because they are not primarily and customarily used to serve a medical purpose and/or are generally useful in the absence of illness or injury. These items would be covered when it is clearly established that they serve a therapeutic purpose in an individual case and would include:

a. Gel pads and pressure and water mattresses (which generally serve a preventive purpose) when prescribed for a patient who has bed sores or there is medical evidence indicating that he is highly susceptible to such ulceration; and

b. Heat lamps for a medical rather than a soothing or cosmetic purpose, e.g., where the need for heat therapy has been established.

In establishing medical necessity (§ 220.2) for the above items, the evidence must show that the item is included in the physician's course of treatment and a physician is supervising its use.

NOTE: The above items represent special exceptions and no extension of coverage to other items should be inferred.

220.2 Necessary and Reasonable.--Although an item may be classified as durable medical equipment, it may not be covered in every instance. Coverage in a particular case is subject to the requirement that the equipment be necessary and reasonable for treatment of an illness or injury, or to improve the functioning of a malformed body member. These considerations will bar payment for equipment which cannot reasonably be expected to perform a therapeutic function in an individual case or will permit only partial payment when the type of equipment furnished substantially exceeds that required for the treatment of the illness or injury involved.

A. Necessity for the Equipment.--Equipment is necessary when it can be expected to make a meaningful contribution to the treatment of the patient's illness or injury or to the improvement of his malformed body member. In most cases the physician's prescription for the equipment will be sufficient to establish that the equipment serves this purpose.

B. Reasonableness of the Equipment.--Even though an item of durable medical equipment may serve a useful medical purpose, the intermediary will also consider to what extent, if any, it would be reasonable for the Medicare program to pay for the item prescribed. The following considerations will enter into the intermediary's determination of reasonableness:

1. Would the expense of the item to the program be clearly disproportionate to the therapeutic benefits which could ordinarily be derived from use of the equipment?

2. Is the item substantially more costly than a medically appropriate and realistically feasible alternative pattern of care?

3. Does the item serve essentially the same purpose as equipment already available to the beneficiary?

The following example points up the applicability of these reasonableness guidelines:

EXAMPLE: The median price of standard whirlpool bath equipment is about $600 plus plumbing expenses necessary to install it in the patient's home. Program coverage of such equipment in the patient's home should be limited to those cases where it is prescribed for conditions where the whirlpool bath can be expected to provide a substantial therapeutic benefit justifying its cost. For example, bursitis or chronic osteoarthritis would not generally justify Medicare payment for whirlpool bath equipment in the home since it would not be reasonable to expect that a whirlpool bath would be significantly more beneficial than a normal warm bath. Moreover, where the patient is not homebound, payment for this item in the patient's home should be restricted to the cost of providing the service elsewhere, e.g., an outpatient department of a participating hospital, if that alternative is less costly.

C. Payment Consistent With What Is Necessary and Reasonable.--Where a claim is filed for equipment containing features of an aesthetic nature or features of a medical nature which are not required by the patient's condition or where there exists a reasonably feasible and medically appropriate alternative pattern of care which is less costly than the equipment furnished, the amount payable is based on the reasonable costs for the equipment or alternative treatment which meets the patient's medical needs.

The provider may not charge the beneficiary for features not medically required by his condition and which cannot be considered in determining the provider's allowable costs unless the beneficiary or his representative has specifically requested the excessive or deluxe item or services with knowledge of the amount he is to be charged.

220.3 Definition of Beneficiary's Home.--For purposes of rental and purchase of durable medical equipment, a beneficiary's home may be his own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. However, an institution may not be considered a beneficiary's home if it:

A. Meets at least the basic requirement in the definition of a hospital (§ 112.1), i.e., it is primarily engaged in providing by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, and sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or

B. Meets at least the basic requirement in the definition of a skilled nursing facility (§ 112.2), i.e., it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

Thus, if an individual is a patient in an institution or distinct part of an institution which provides the services described in A or B above, he is not entitled to have payment made for rental or purchase of durable medical equipment since such an institution may not be considered his home.

When the beneficiary is at home for part of a month and is in an institution which cannot qualify as his home for a part of the same month, payment may be made for the entire month. However, where the provider charges for only part of a month in such a case payment will be made on a prorated basis.

220.4 Repairs, Maintenance, Replacement, and Delivery.--Under the circumstances specified below, payment may be made for repair, maintenance, and replacement of medically required durable medical equipment which the beneficiary owns or is purchasing, including equipment which had been in use before the user enrolled in Part B of the program. Since renters of equipment usually recover from the rental charge the expenses they incur with respect to maintaining in working order the equipment they rent out, separately itemized charges for repair, maintenance, and replacement of rented equipment are not covered.

A. Repairs.--Repairs to equipment which a beneficiary is purchasing or already owns are covered when necessary to make the equipment serviceable. If the expense for repairs exceeds the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need, no payment can be made for the amount of the excess. Claims for repairs which suggest malicious damage or culpable neglect should be reported to the intermediary.

B. Maintenance.--Routine periodic servicing, such as testing, cleaning, regulating, and checking of the beneficiary's equipment is not covered. Such routine maintenance is generally expected to be done by the owner rather than by a retailer or some other person who would charge the beneficiary. Normally, purchasers of durable medical equipment are given operating manuals which describe the type of servicing an owner may perform to properly maintain the equipment. Thus, hiring a third party to do such work would be for the convenience of the beneficiary and would not be covered.

However, more extensive maintenance which, based on the manufacturers' recommendations, is to be performed by authorized technicians, would be covered as repairs. This might include, for example, breaking down sealed components and performing tests which require specialized testing equipment not available to the beneficiary.

C. Replacement.--Replacement of equipment which the beneficiary owns or is purchasing is covered in cases of loss or irreparable damage or wear and when required because of a change in the patient's condition. Expenses for replacement required because of loss or irreparable damage may be reimbursed without a physician's order when in the judgment of the intermediary the equipment as originally ordered, considering the age of the order, would still fill the patient's medical needs. However, claims involving replacement equipment necessitated because of wear or a change in the patient's condition should be supported by a current physician's order.

Cases suggesting malicious damage, culpable neglect, or wrongful disposition of equipment should be reported to the intermediary.

D. Delivery.--Reasonable costs for delivery of durable medical equipment whether rented or purchased are covered if the provider customarily makes separate charges for delivery and this is a common practice among the other local providers.

220.5 Coverage of Supplies and Accessories.--Reimbursement may be made for supplies, e.g., oxygen, only when essential to the effective use of medically necessary durable medical equipment. Medications which may be used in connection with durable medical equipment are generally not covered.

Medications fall within the drug restriction and are, therefore, not covered under Part B except for those which cannot be self-administered and are provided as incident to a physician's professional services. This exception would apply to tumor chemotherapy agents such as methotrexate, 5-fluorouracil, and FUDR when used in conjunction with an infusion pump which is considered to be durable medical equipment. Such drugs and related services in charging or recharging the pump are covered only when furnished by a physician or by a technician under circumstances which satisfy the requirements for coverage of the services of auxiliary personnel rendered "incident to" a physician's service (i.e., provided under his personal supervision with the charges for such services included in the physician's bill).

Reimbursement may be made for replacement of essential accessories such as hoses, tubes, mouth pieces, etc., for necessary durable medical equipment, only if the beneficiary owns or is purchasing the equipment.

220.6 Miscellaneous Issues Included in the Coverage of Equipment.--Payment can be made for the purchase of durable medical equipment even though rental payments may have been made for prior months. This could occur where, because of a change in his condition, the beneficiary feels that it would be to his advantage to purchase the equipment rather than to continue to rent it. When such a situation occurs, the provider may deduct all or part of the rentals paid from the purchase price of the equipment.

A beneficiary may sell or otherwise dispose of equipment for which he has no further use, for example, because of recovery from the illness or injury which gave rise to the need for the equipment. (There is no authority for the program to repossess the equipment.) If after such disposal there is again medical need for similar equipment, payment can be made for the rental or purchase of that equipment.

However, where an arrangement is motivated solely by a desire to create artificial expenses to be met by the program and to realize a profit thereby, such expenses would not be covered under the program. The resolution of questions involving the disposition and subsequent acquisition of durable medical equipment must be made on a case-by-case basis.

Cases where it appears that there has been an attempt to create an artificial expense and realize a profit thereby should be reported to the intermediary.

When payments stop because the beneficiary's condition has changed and the equipment is no longer medically necessary, he is responsible for the remaining noncovered charges. Similarly, when payments stop because the beneficiary dies, his estate is responsible for the remaining noncovered charges.

220.7 Payment for Durable Medical Equipment.--

A. The Decision to Rent or Purchase.--A beneficiary may elect to rent an item of equipment rather than purchase it even though it may appear that purchase would be more economical for the program. However, the intermediary will determine the method of payment to be used by the program in making reimbursement for equipment that is purchased. In both rental and purchase on a periodic payment basis, the monthly amount payable to the provider is converted to estimated costs by using the established outpatient cost reimbursement rate.

1. Rental Payments.—Where a provider rents durable medical equipment to a beneficiary, the provider will be reimbursed 80 percent of the reasonable cost of making the equipment available less any unmet deductible. Where the provider rents the equipment to the patient, it submits an SSA-1483 for each month's rental charge. The patient is responsible to the provider for any unmet deductible and the monthly coinsurance.

2. Purchase of Equipment.—Where the provider sells the equipment to the patient, it submits one SSA-1483 to the intermediary showing the purchase price. The intermediary prepares an SSA-1483 for each month it makes payment showing the amount of the periodic payment for that month. The provider may either bill the patient once for his deductible and coinsurance liability or submit a bill to him each month. When equipment is purchased, the intermediary determines in accordance with the following guidelines whether program payment is to be made in a lump sum or in periodic payments.

a. Lump-Sum Payment for Inexpensive Equipment.—Payment for inexpensive equipment will be made in a lump sum subject to the deductible and coinsurance when it is determined to be less costly or more practical to do so. Inexpensive equipment is normally any item of durable medical equipment for which the reasonable charge is $50 or less.

b. Periodic Payment.—Where payment is not made in a lump sum, benefits will be paid in monthly installments equivalent to the payment that would have been made had the equipment been rented. However, periodic payments may be made only for the established period of medical necessity for the item or until the total program payments to the provider equal 80 percent of the estimated cost of the item, whichever comes first. The periodic payments are subject to the deductible and coinsurance provisions. While periodic payments will be made on a monthly basis, a single payment can be made for periodic payments which have accrued.

B. When Expenses are Incurred.—The first month's expense for rental of durable medical equipment is deemed incurred as of the date of delivery of the equipment for purposes of crediting the SMI deductible and for reimbursement. Expenses for subsequent months are incurred as of the same day of the month as the date of delivery. Where equipment is purchased, the periodic monthly benefits will be payable on the same basis. Providers may submit claims as of the date the expenses are incurred and the date of delivery should be specified on the bill.

EXAMPLE: In August 1973, Mr. Thomas, a paraplegic, signed an agreement with an HHA to purchase a wheelchair for $200 to use in his home. The wheelchair was delivered to him on September 8, 1973, and the HHA submitted a bill. The intermediary determined the reasonable rental charge was $20 a month. Since Mr. Thomas did not have any other covered Part B expenses during the year, periodic payments for September 1973, October 1973, and November 1973, were withheld to satisfy the deductible. The first payment became payable on December 8, 1973. Since $40 of the deductible was met in the last quarter of 1973, payment for January 1974 was withheld to satisfy the remaining deductible of $20 for 1974. Periodic payments resumed February 8, 1974.

C. Determining Months for Which Periodic Payments May be Made for Purchased Equipment.—No payment may be made for any month throughout which the patient is in an institution which does not qualify as his home. Where equipment is purchased by a patient for use in his home and he is subsequently admitted to a hospital or SNF which does not meet the definition of the patient's home (§ 220.3), payments should be suspended. Upon return of the patient to his home, payments should resume without loss of monthly installments because of the institutionalization. Assuming the deductible is met, payments would continue as long as the equipment is medically necessary or until 80 percent of the reasonable purchase price has been reimbursed, whichever occurs first. The following example illustrates the application of this policy.

EXAMPLE: Mrs. Jones, who had already met her deductible, purchased a wheelchair on February 1, which she used in her home until her admission to the hospital on April 15. She was discharged from the hospital to her home on June 15 and continued to need the wheelchair. The reasonable charge for the wheelchair was $150 and the reasonable rental charge was $15 per month. The intermediary scheduled 10 monthly payments of $12 each (80 percent of $15) and paid for February, March, and April. Since Mrs. Jones was hospitalized for the entire month of May, the fourth installment was suspended. This installment became the June payment, and payments continued through December rather than November, as originally scheduled.

D. Durable Medical Equipment Purchased Before Beneficiary's Coverage Begins.—The dates on which periodic payments for a covered purchased item are due and allocation of the installments for deductible purposes are determined under the rules in B above. However, in determining whether a purchased item is covered, the entire expense of the item is considered to have been incurred on the date the equipment was delivered to an individual. Accordingly, where a purchased item of durable medical equipment was delivered to an individual before his coverage period began, the entire expense of the item (whether it was paid for in its entirety at the time of purchase or on a deferred or installment basis), would be excluded from coverage since payment cannot be made for any expense incurred before an individual's coverage period began.

NOTE: Any items which are covered as durable medical equipment would also meet the requirements for coverage under the definition of medical appliances for purposes of the home health benefit. However, the definition of medical appliances under the home health benefit provides for the coverage of certain additional items which are not covered as durable medical equipment. (See § 206.3B.)

221. AMBULANCE SERVICE

Ambulance service is covered only under Part B. The cost of oxygen and its administration in connection with and as part of ambulance service is also covered. The Part A intermediary is responsible for the processing of claims for ambulance service furnished by participating home health agencies and has responsibility for determining the compliance of the home health agency's ambulance and crew. Provider ambulance services furnished "under arrangements" with suppliers can be covered, only if the supplier meets the conditions discussed below. (See § 224 for the required certification for ambulance services.)

Where a home health agency finds it necessary to have a beneficiary transported by ambulance to a hospital or skilled nursing facility to obtain home health services not otherwise available to the individual, the trip is covered as a Part B service only if the coverage requirements below are met. Such transportation is not covered as a home health service.

221.1 Vehicle and Crew Requirements.—

A. Vehicle.—The vehicle must be a specially designed and equipped automobile or other vehicle (in some areas of the United States this might be a boat or plane) for transporting the sick or injured. It must have customary patient care equipment including a stretcher, clean linens, first aid supplies, oxygen equipment, and it must also have such other safety and lifesaving equipment as is required by State or local authorities.

B. Crew.—The ambulance crew must consist of at least two members. Those crew members charged with the care or handling of the patient must include one individual with adequate first aid training; i.e., training at least equivalent to that provided by the standard and advanced Red Cross first aid courses. Training "equivalent" to the standard and advanced Red Cross first aid training courses includes ambulance service training and experience acquired in military service, successful completion by the individual of a comparable first aid course furnished by or under the sponsorship of State or local authorities, an educational institution, a fire department, a hospital, a professional organization, or other such qualified organization. On-the-job training involving the administration of first aid under the supervision of or in conjunction with trained first aid personnel for a period of time sufficient to assure the trainee's proficiency in handling the wide range of patient care services that may have to be performed by a qualified attendant can also be considered as "equivalent training."

C. Equipment and Supplies.--As mentioned above, the ambulance must have customary patient care equipment and first aid supplies. Reusable devices and equipment such as backboards, neckboards and inflatable leg and arm splints are considered part of the general ambulance service and would be included in the cost of the trip. On the other hand, a separate cost based on actual quantities used may be recognized for nonreusable items and disposable supplies such as oxygen, gauze and dressings required in the care of the patient during his trip.

221.2 Necessity and Reasonableness.--To be covered, ambulance service must be medically necessary and reasonable.

A. Necessity For the Service.--Medical necessity is established when the patient's condition is such that the use of any other method of transportation is contraindicated. In any case, in which some means of transportation other than an ambulance could be utilized without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance service.

B. Reasonableness of the Ambulance Trip.--A claim may be denied on the ground that the use of ambulance service was unreasonable in the treatment of the illness or injury involved (§ 232.1) notwithstanding the fact that the patient's condition may have contraindicated the use of other means of transportation.

221.3 The Destination.--As a general rule, only local transportation by ambulance is covered. This means that the patient must have been transported to an institution (i.e., a hospital or a skilled nursing facility) whose locality (see paragraph D below) encompasses the place where the ambulance transportation of the patient began and which would ordinarily be expected to have the appropriate facilities for the treatment of the injury or illness involved. In exceptional situations where the ambulance transportation originates beyond the locality of the institution to which the beneficiary was transported, full payment may be made for such services only if the evidence clearly establishes that such institution is the nearest one with appropriate facilities (see paragraph E below).

The institution to which a patient is transported need not be a participating institution. However, in the case of a hospital, it must meet at least the requirements of § 112.1A. In the case of a skilled nursing facility, it must be an institution which is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

The intermediary generally will not deny a claim for ambulance service to a participating hospital or skilled nursing facility merely on the grounds that there is a nearer nonparticipating institution having appropriate facilities.

A. Institution to Beneficiary's Home.--Ambulance service from an institution to the beneficiary's home is covered when his home is within the locality of such institution or where the beneficiary's home is outside of the locality of such institution and the institution in relation to his home is the nearest one with appropriate facilities.

B. Institution to Institution.--Occasionally, the institution to which the patient is initially taken is found to have inadequate facilities for treating him and he is then transported to a second institution having appropriate facilities. In such cases, transportation by ambulance to both institutions would be covered provided the institution to which he is being transferred is determined to be the nearest one with appropriate facilities. In these cases, transportation from such second institution to the patient's home could be covered if his home is within the locality serviced by that institution or by the first institution to which he was taken.

C. Partial Payment.--Partial reimbursement may be made for otherwise covered ambulance service which exceeded the limits defined above. Such payment should be based on the amount that would have been payable had the patient been transported from the pick-up point to the nearest appropriate facility. However, when the beneficiary was transported from a distant hospital or skilled nursing home to his residence, payment should be based on the amount that would have been payable had the beneficiary been transported to his residence from the nearest institution with appropriate facilities.

D. Locality.--The term "locality" with respect to ambulance service means the service area surrounding the institution from which individuals normally come or are expected to come for hospital or skilled nursing services.

EXAMPLE: Mr. A becomes ill at home and requires ambulance service to the hospital. The small community in which he lives has a 35-bed hospital. Two large metropolitan hospitals are located some distance from Mr. A's community but they regularly provide hospital services to the community's residents. The community is within the "locality" of the metropolitan hospitals and direct ambulance service to either of these (as well as to the local community hospital) is covered.

E. Appropriate Facilities.--The term "appropriate facilities" means that the institution is generally equipped to provide the needed hospital or skilled nursing care for the illness or injury involved. It is the institution, its equipment, its personnel, and its capability to provide the services necessary to support the required medical care that determine whether it has appropriate facilities.

EXAMPLE: Mr. A becomes ill at home and requires ambulance service to the hospital. The hospitals servicing the community in which he lives are capable of providing general hospital care. However, Mr. A requires immediate kidney dialysis but the needed equipment is not available in any of these hospitals. The service area of the nearest hospital having dialysis equipment does not encompass the patient's home. Nevertheless, in this case, ambulance service beyond the locality to the hospital with the equipment would be covered since it is the nearest one with appropriate facilities.

The fact that a more distant institution is better equipped, either qualitatively or quantitatively, to care for the patient does not warrant a finding that a closer institution does not have "appropriate facilities." However, a legal impediment barring a patient's admission would permit a finding that the institution did not have "appropriate facilities." For example, the nearest tuberculosis hospital may be in another State and that State's law precludes admission of nonresidents.

An institution is not considered an appropriate facility if there is no bed available. The carrier, however, will presume that there are beds available at the local institutions unless evidence is furnished that none of these institutions had a bed available at the time the ambulance service was provided.

The individual physician who practices in a hospital is not a consideration in determining whether the hospital has appropriate facilities. Thus, ambulance service to a more distant hospital solely to avail a patient of the service of a specific physician or a physician in a specific specialty does not make the hospital in which the physician has staff privileges the nearest hospital with appropriate facilities.

F. Ambulance Service to a Physician's Office Is Not Covered.—There may be situations, however, where in the course of transporting a patient to a hospital, the ambulance stops at a physician's office because of the patient's dire need for professional attention and immediately thereafter the ambulance continues the trip to the hospital. In such cases, the patient will be deemed not to have been transported to the physician's office and payment may be made for the entire trip.

G. Coverage of Ambulance Service Furnished a Deceased Beneficiary.—An individual is considered to have expired as of the time he is pronounced dead by a person who is legally authorized to make such a pronouncement, usually a physician. Therefore, if the beneficiary was pronounced dead by a legally authorized individual before the ambulance was called, no program payment may be made. Where the beneficiary was pronounced dead after the ambulance was called but before pickup, the service to the point of pickup is covered. If otherwise covered ambulance services were furnished to a beneficiary who was pronounced dead while enroute to or upon arrival at the destination, the entire ambulance service is covered.

222. SPECIAL OPTION FOR PATIENTS UNDER A HOME HEALTH PLAN WHO REQUIRE PHYSICAL THERAPY OR SPEECH PATHOLOGY SERVICES OR THE USE OF MEDICAL APPLIANCES

There may be instances where it will be to the patient's advantage to receive the physical therapy or speech pathology services he needs as "medical and other health services" rather than as a home health service. Effective July 1, 1981, since unlimited home health visits are available, it would be disadvantageous for the beneficiary to use this special option for outpatient physical therapy or speech pathology services. Also, a patient may choose to purchase durable medical equipment rather than to have the use of it paid for under the home health plan. In such an instance the home health agency should explain this option to the patient.

A.. Outpatient Physical Therapy or Speech Pathology Services (Furnished Prior to July 1, 1981).—The home health agency should advise a home health patient who needs physical therapy or speech pathology services in addition to skilled nursing visits that he may wish to consider whether it would be advantageous for him to receive the physical therapy or speech pathology services he needs as a Part B "medical and other health service" (subject to the Part B deductible and coinsurance, see § 160ff.), thus conserving his 100 visit home health benefit (either under Part A or Part B) for the nursing visits and any other covered home health visits he may require which are not reimbursable as "medical and other health services." (In addition, it has been determined that a patient who does not require skilled nursing care may choose to receive physical therapy or speech pathology services from a home health agency as "medical and other health services" and, on the basis of the need for these services, also receive covered home health services.) However, generally, it will be to the advantage of the home health beneficiary to choose to receive these services as a home health benefit (either under Part A or Part B) since home health services are not subject to the 20 percent coinsurance, unless the patient wishes to conserve his home health visits (see §§ 160.5 and 450.1).

B. Use of Medical Appliances.—A patient who is receiving home health visits (either under Part A or Part B) and who will need the use of a medical appliance over an extended period of time should be advised by the home health agency that if the appliance meets the coverage requirements for durable medical equipment (§ 220), he has an option to choose to have the use of the appliance reimbursed under the home health benefit or to have reimbursement made for the purchase of durable medical equipment from the home health agency or from an independent supplier as a "medical and other health service." Generally, it is to the advantage of the home health beneficiary to choose to receive these items as home health services.

223. PATIENT HAS SATISFIED PART B DEDUCTIBLE (Services Prior to July 1, 1981)

If the patient has already satisfied the Part B deductible in the calendar year (see sections 160.3-160.6), this will be indicated on the Part B Home Health Benefits Record he receives from the Health Care Financing Administration after a Part B home health services claim is processed, or on the Explanation of Medicare Benefits form he receives from the intermediary after other Part B claims are processed (see section 306). On claims for services furnished prior to July 1, 1981, the agency should attempt to ascertain whether or not the patient has satisfied the deductible before charging him for this amount.

NOTE: There are no deductible or coinsurance requirements for home health visits furnished under the hospital insurance program. Reimbursement for such services consists of the total reasonable costs of the covered home health services furnished.

224. PHYSICIAN CERTIFICATION FOR MEDICAL AND OTHER HEALTH SERVICES

A physician must certify that the medical and other health services covered by medical insurance which were provided by (or under arrangements made by) the home health agency were medically required. (See section 219.4A3 for the special physician certification requirements applicable to outpatient physical therapy and speech pathology services.) This certification needs to be made only once where the patient may require over a period of time the furnishing of the same item or service related to one diagnosis There is no requirement that the certification be entered on any specific form or handled in any specific way as long as the approach adopted by the home health agency permits the intermediary to determine that the certification requirement is, in fact, met. A physician's written order designating the services required would also be an acceptable certification.

If ambulance service is furnished by a home health agency, an additional certification is required. It may be furnished by any physician who has sufficient knowledge of the patient's case including the physician who requested the ambulance or the physician who examines the patient upon his arrival at the facility. The physician must certify that the ambulance service was medically required.

225. PROVIDER-BASED PHYSICIANS

Home health agencies may have on their staffs, on a full-time or part-time basis, salaried physicians who are engaged in a full range of activities, including administration, supervision of professional or technical personnel, service on committees, as well as direct medical services to individual patients. To make payment under the health insurance program, it is necessary to distinguish the medical or surgical services rendered by a physician to an individual patient which are reimbursable under Part B on a reasonable charge basis, and provider services (including the physician's services for the home health agency) reimbursable on a reasonable cost basis.

A. Distinguishing Between Professional and Provider Components.--The services of provider-based physicians contain two distinct elements, the ofessional component and the provider component.

1. The Professional Component.--The medical insurance program (Part B) provides reimbursement on a reasonable charge basis for physicians services directly related to the medical care of individual patients.

In order for a service to be reimbursable as a physician's service, it must constitute an integral part or result from the physician's personal contact with and care of the patient and be included in his bill for the personal contact. For example, a physician would not bill a patient for the establishment or review of a plan of treatment or for making a physician certification; however, the time spent in such activities is generally calculated into his usual charge for the home or office visit related to such patient care. Thus, chart reviews of patients, the changing of medical orders and prescriptions, review of a plan of treatment, and other similar functions carried out by a physician in a home health agency may not be separately reimbursed as a physician's service but would be included in the physician's charge for a personal contact visit with the provider.

2. The Provider Component.--Home health agency-based physicians may also perform services other than those directly related to the medical care of individual patients. These involve services which benefit the

patients of the agency as a group. For example, such services may include in-service training of the home health agency's paramedical personnel, consultations with paramedical personnel concerning individual patient cases, and administrative services. Costs incurred for these services will be considered in computing reimbursable agency costs and will be reflected in amounts payable to the agency for services rendered to Medicare beneficiaries.

3. Compensation Allocation.--Ordinarily the compensation paid to the physician is for all services he performs in proportion to the time he devotes to each activity. It is a primary obligation of the home health agency and the provider-based physician to mutually agree upon the allocation of compensation based on the time the physician spends in his various activities, and communicate this information with supporting documentation to the intermediary. The supporting material should include a written explanation of the basis for the allocation agreement. The arrangement between the home health agency and the provider-based physician does not generally support a 100 percent allocation of compensation for either direct patient services (Part B) or provider services (Part A). The allocation must be based on facts, sufficiently documented to support the necessary determination and should include a written agreement signed by the provider and physician. Where the agreed-upon allocation is not consistent with similar arrangements between home health agencies and provider-based physicians or does not appear reasonable, the intermediary will obtain more detailed information including time studies, as necessary.

B. The Schedule of Charges.--A schedule of charges must be designed to yield, in the aggregate, as nearly as possible, an amount equal to the portion of the physician's compensation represented by the professional component. This can be compiled by using a charge per medical service, or by using a charge per visit. The aggregate charges under either method, however, may not exceed that portion of the provider-based physicians' Part B component attributable to direct patient services rendered to Medicare beneficiaries.

C. Billing for the Physician's Charge for Direct Patient Services.--Reimbursement is made on a reasonable charge basis for physicians' services by the medical insurance (Part B) carrier. Therefore, the charges of home health agency-based physicians, i.e., salaried physicians employed by the home health agency on a full or part-time basis, for medical services rendered to individual patients of the home health agency must be specially billed. Claims for such physicians' services rendered to patients of the home health agency may be made by:

1. the physician on an SSA-1490, if he accepts assignment

2. the patient on an SSA-1490, or

3. the home health agency on an SSA-1554. (See § 470 for this type of billing.)

D. Authorization to Accept Assignment.--The following is a sample of an authorization for use by the agency in connection with billing for physicians' services. A one-time execution of this authorization is all that is necessary by each physician. The authorization should be retained in the provider's files.

"I hereby authorize the (name of the agency) or any of its duly authorized administrators to accept on my behalf any assignment made by any individual who received medical treatment from me of the amount payable to such individual under Part B of Title XVIII of the Social Security Act and to receive on my behalf any payments which may be made pursuant to such assignment. It is understood and agreed that the reasonable charge which will serve as the basis for payment in accordance with the terms of such assignment shall be the full charge for the services."

An additional statement should also include the individual arrangements agreed upon by the agency and the physician governing the conditions of withdrawing the authorization.

E. Duties and Responsibilities of Home Health Agencies.--It is the duty and responsibility of the home health agency to supply the intermediary not only all of the data necessary for it to make reasonable cost reimbursement, but also with the information required by the carrier to make reasonable charge determinations for the services of physicians rendering direct patient services in this provider setting. Whenever the nature or number of services rendered by the physician changes or when the compensation arrangement between the home health agency and physician is re-negotiated or adjusted, an appropriate notice should be sent to the Part A intermediary.

Home health agencies should feel free to contact their intermediary for any necessary assistance in preparing the provider-physician compensation allocation agreement and/or the schedule of charges based on the physician's professional component.

230. SPECIFIC EXCLUSIONS FROM COVERAGE AS HOME HEALTH SERVICES

In addition to the general exclusions from coverage under health insurance listed in § 232, the following are also excluded from coverage as home health services:

A. Services or items which would not be paid for if provided to an inpatient of a hospital, such as private duty nursing service, or items of comfort which are not necessary for treatment, e.g., television.

B. Meals-on-wheels or similar food service arrangements.

C. Domestic or housekeeping services which are unrelated to patient care.

D. Transportation services, e.g., from place of residence to a facility to receive home health services on an outpatient basis.

General Exclusions from Coverage

232. GENERAL EXCLUSIONS

No payment can be made under either the hospital insurance or supplementary medical insurance program for certain items and services.

A. Not reasonable and necessary (§ 232.1);

B. No legal obligation to pay for or provide (§ 232.2);

C. Paid for by a governmental entity (§ 232.3);

D. Not provided within United States (§ 232.4);

E. Resulting from war (§232.5);

F. Personal comfort (§232.6);

G. Routine services and appliances (§232.7);

H. Supportive devices for feet (§232.8);

I. Foot care exclusion (§232.9);

J. Custodial care (§232.10);

K. Cosmetic surgery (§232.11);

L. Dental services (§232.13);

M. Paid or expected to be paid under workers' compensation (§232.14).

232.1 Services Not Reasonable and Necessary.-- Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member are not covered.

232.2 No Legal Obligation to Pay for or Provide Services.-- Program payment may not be made for items or services which neither the beneficiary nor any other person or organization has a legal obligation to pay for or provide. This exclusion applies where items and services are furnished gratuitously without regard to the beneficiary's ability to pay and without expectation of payment from any source, such as free x-rays or immunizations provided by health organizations. However, Medicare reimbursement is not precluded merely because a provider, physician, or supplier waives the charge in the case of a particular patient or a group or class of patients, as the waiver of charges for some patients does not impair the right to charge others, including Medicare patients. The determinative factor in applying this exclusion is the reason the particular individual is not charged.

The following sections illustrate the applicability of this exclusion to various situations involving services other than those paid for directly or indirectly by a governmental entity. (For a discussion of the latter, see §232.3.)

A. Indigency.-- This exclusion does not apply where items and services are furnished an indigent individual without charge because of his inability to pay, if the provider, physician, or supplier bills other patients to the extent that they are able to pay.

B. Provider, Physician, or Supplier Bills Only Insured Patients.-- Some providers, physicians, and suppliers waive their charges for individuals of limited means, but they also expect to be paid where the patient has insurance which covers the items or services they furnish. In such a situation, because it is clear that a patient would be charged if insured, benefits are payable for services rendered to patients with medical insurance if the provider, physician, or supplier customarily bills all insured patients--not just Medicare patients--even though non-insured patients are not charged.

Individuals with conditions which are the subject of a research project may receive treatment financed by a private research foundation. The foundation may establish its own clinic to study certain diseases or it may make grants to various other organizations. In most cases, the patient is not expected to pay for his treatment out-of-pocket, but if he has insurance, the parties expect that the insurer will pay for the services. In this situation, a legal obligation is considered to exist in the case of a Medicare patient even though other patients may not have insurance and are not charged.

C. **Medicare Patient Has Other Health Insurance.**-- Except as provided in §§251ff., 252ff. and 253ff. payment is not precluded under Medicare even though the patient is covered by another health insurance plan or program which is obligated to provide or pay for the same services. This plan may be the type which pays money toward the cost of the services, such as a health insurance policy, or it may be the type which organizes and maintains its own facilities and professional staff. Examples of this latter type are employer and union sponsored plans which furnish services to special groups of employees or retirees or to union members, and group practice prepayment plans.

The exceptions to this rule are: (1) services covered by automobile medical or no-fault insurance (§§251ff.), (2) services rendered during a specified period of up to 12 months to individuals entitled solely on the basis of ESRD who are insured under an employer group health plan (§§252ff.) (3) services rendered employed individuals and their spouses aged 65 through 69 who are insured under an employer group health plan (§§253ff.) and (4) services covered by workers' compensation (§§250ff.). In these cases the other plan pays primary benefits and, if the other plan doesn't pay the entire bill, secondary Medicare benefits may be payable. Medicare is also secondary to the extent that services have been paid for by a liability insurer. (See §§251ff.)

D. **Members of Religious Orders.**-- A legal obligation to pay exists where a religious order either pays for or furnishes services to members of the order. Although medical services furnished in such a setting would not ordinarily be expressed in terms of a legal obligation, the order has an obligation to care for its members who have rendered lifelong services, similar to that existing under an employer's prepayment plan. Thus, payment may be made for such services whether they are furnished by the order itself or by independent sources that customarily charge for their services.

232.3 **Items and Services Furnished, Paid for or Authorized by Governmental Entities--Federal, State or Local Governments.**—The law contains three separate exclusions applicable to items and services furnished, paid for or authorized by governmental entities. In general, payment may not be made for: (1) items and services furnished by a provider of services or agency of the Federal government (§232.3A); (2) items and services which a provider (Governmental or nongovernmental) or other person furnishes at public expense pursuant to an authorization issued by a Federal agency (§232.3B); and (3) items or services paid for directly or indirectly by a Federal, State, or local governmental entity (§232.3C). Each of these exclusions is applied separately; i.e., benefits would be excluded where any one of the exclusions applies.

A. Items and Services Furnished by a Federal Provider of Services or Federal Agency.-- Generally, Federal providers are excluded from participation in the Medicare program. (However, Federal hospitals, like other nonparticipating hospitals, may be paid for emergency inpatient and outpatient hospital services. A provider or other facility acquired by the Department of Housing and Urban Development (DHUD) in the administration of an FHA mortgage insurance program is not considered to be a Federal provider or agency and this exclusion is not applicable to services furnished by such facilities.) The law provides exceptions to this exclusion which permit the following categories of Federal providers to participate in Medicare:

1. A Federal provider which is determined to be providing services to the public generally as a community institution or agency. VA hospitals which have sharing agreements with non-VA participating hospitals, under which the VA hospitals furnish ESRD services to nonveterans, may be considered community hospitals with respect to any otherwise covered service rendered ESRD beneficiaries. This exception does not apply to Federal clinics or other health facilities which are not "providers of services" as defined in the Medicare law, i.e., which are not hospitals, SNFs, HHAs or CORFs.

2. Hospitals and SNFs of the Indian Health Service (IHS).

B. Items and Services Which a Provider Is Obligated to Furnish at Public Expense Pursuant to an Authorization Issued by a Federal Agency-- Medicare payment may not be made for any item or service rendered by a provider pursuant to an authorization issued by a Federal agency, under the terms of which the Federal government agrees to pay for the services.

However, in the case of contract health services to Indians and their dependents entitled under the IHS program and Medicare, Medicare will be the primary payer and the IHS the secondary payer.

C. Items and Services Which Have Been Paid for Directly or Indirectly by a Government Entity.—Medicare payment may not be made for items or services paid for directly or indirectly by a Federal, State or local governmental entity. However, the law specifies that this exclusion does not prohibit payment for: (1) items or services furnished under a health benefits or insurance plan established for employees of the governmental entity; or (2) items or services furnished under one of the titles of the Social Security Act (such as medical assistance under title XIX); or (3) rural health clinic services.

Except for the two categories of facilities referred to below, payment may not be made for items and services which a State or local government facility furnishes free of charge; i.e., without expectation of payment from any source and without regard to the individuals' ability to pay. A facility which reduces or waives its charges for patients unable to pay, or charges patients only to the extent of their Medicare and other health insurance coverage, is not viewed as furnishing free services and may therefore receive program payment.

Medicare regulations permit payment to the following two categories of governmental providers even though they furnish services free of charge:

a. Payment may be made for items and services furnished by a participating State or local government hospital, including a psychiatric or tuberculosis hospital, which serves the general community. A psychiatric hospital to which patients convicted of crimes are committed involuntarily is considered to be serving the general community if State law provides for voluntary commitment to the institution. However, payment may not be made for services furnished in State or local hospitals which serve only a special category of the population, but do not serve the general community, e.g., prison hospitals.

b. Payment may be made for items and services paid for by a State or local governmental entity and furnished an individual as a means of controlling infectious disease or because the individual is medically indigent.

Payment may not be made for items or services furnished by a nongovernmental provider where the charges have been paid for by a government program other than Medicare, or where the provider intends to look to another government program for payment, unless the payment by the other program is limited to the Medicare deductible and coinsurance amounts.

D. Illustrations.-- The following paragraphs discuss the application of these exclusions to services covered by various governmental programs.

1. Veterans Administration.--

a. General.-- Services furnished without charge by a VA facility or by VA physicians and other VA employees are excluded from coverage under title XVIII. In addition, as explained below, the fact that a beneficiary is eligible to have services furnished by private sources paid for by the VA precludes payment for them under title XVIII. It will generally be advantageous for health insurance beneficiaries to have services paid for under a VA program where possible since the VA has no deductible or coinsurance requirements.

b. Physicians' Services.-- Under its Home Town Care Medical Program, the VA may authorize payment for services furnished by private physicians to veterans for their service-connected disabilities. Where treatment under a VA program has been authorized, no payment can be made under Part B, nor can the services paid for under the VA program be counted toward the Part B deductible. On the other hand, where the veteran does not request authorization from the VA, he may have payment made under Part B even though he might have been entitled to have payment made under a VA program if he had asked for authorization.

2. Government Research Grants.-- A beneficiary who would be eligible to have his care paid for by a governmental research grant can receive benefits under title XVIII, if the facility charges those patients who have Medicare or other insurance. Where a provider or supplier of services claims benefits under title XVIII, it may not also accept research grant funds for the services in question, except to the extent of the deductible and coinsurance amounts.

3. State or Local Health Department Clinics.-- Many State or local health departments operate outpatient clinics. Servcies rendered by such clinics free of charge because of the individual's indigency or as a means of controlling infectious diseases (e.g., city-operated charity clinics and clinics for the detection and treatment of veneral disease and tuberculosis) are covered under title XVIII.

4. CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) and CHAMPVA (Civilian Health and Medical Program of the Veterans Administration).--

a. General.-- CHAMPUS AND CHAMPVA are similar programs administered by the Department of Defense, except that the Veterans Administration determines the eligibility of persons seeking to establish entitlement to CHAMPVA coverage. CHAMPUS provides benefits for health care services furnished by civilian providers, physicians, and suppliers to retired members of the Uniformed Services and to spouses and children of active duty, retired, and deceased members. The term "Uniformed Services" includes the Army, Navy, Air Force, Marine Corps, Coast Guard, and the Oceanic and Atmospheric Administration. CHAMPVA provides similar benefits for spouses and children of veterans who are entitled to VA permanent and total disability benefits and to widows and children of veterans who died of service-connected disabilities.

The governmental entity exclusion does not preclude Medicare payment for items or services furnished to a beneficiary who is also eligible for CHAMPUS/CHAMPVA benefit payments for the same services. Medicare is the primary payer for such items and services, and CHAMPUS/CHAMPVA is a supplementary payer. (See c below.)

b. Effect to Medicare Eligibility on CHAMPUS/CHAMPVA Entitlement.-- CHAMPUS/CHAMPVA beneficiaries, other than dependents of active duty members, lose their entitlement to CHAMPUS/CHAMPVA if they qualify for Medicare Part A on any basis other than the premium-HI provisions (see §168). Individuals who are eligible for Medicare Part B benefits only, as well as dependents of active duty members, are also eligible for CHAMPUS/CHAMPVA benefits.

c. Medicare-CHAMPUS/CHAMPVA Relationship.--CHAMPUS/CHAMPVA will reduce its liabiity in all cases by the amount payable by Medicare, i.e., Medicare will be the primary payer and CHAMPUS/CHAMPVA will supplement Medicare by paying the Medicare deductible and coinsurance amounts and portions of the bill not covered by Medicare. Thus, dually entitled individuals may be reimbursed up to 100 percent of expenses for items and services covered by both programs.

CHAMPUS/CHAMPVA has established policies and procedures which provide for (a) the identification of claimants who have coverage under both CHAMPUS/CHAMPVA and Medicare and (b) the detection of duplicate payments under both programs. If CHAMPUS/CHAMPVA inadvertently pays amounts which duplicate Medicare payments for the same items or services, CHAMPUS/CHAMPVA will take steps to recover the incorrect CHAMPUS/CHAMPVA payments.

5. Active Duty Members of the Uniformed Services.-- In limited circumstances, active duty members of the Uniformed Services may have care in civilian facilities paid for by the Army, Navy, Air Force, Marine Corps, or other appropriate uniformed service. Except for emergency services, prior approval is generally required before such payment can be made. Services furnished pursuant to such approval and services paid for or expected to be paid for by the Uniformed Services are not reimbursable under Medicare.

232.4 Services Not Provided Within the United States.--Items and services which are not provided within the United States are not covered, except for emergency inpatient services furnished outside the United States under certain limited conditions and ambulance services furnished by an American supplier to transport the patient to the foreign hospital for such services. (Under the Railroad Retirement Act, Medicare payment may also be made by the Railroad Retirement Board on behalf of qualified railroad retirement beneficiaries for covered hospital services furnished in Canadian hospitals.)

The term "United States" means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa, and includes the territorial waters adjoining these entities. Generally speaking, the 3-mile limit off the shores of most of the United States constitutes American territory. In the case of Texas and Florida, the limit extends into the Gulf of Mexico within 9 miles (3 leagues) off the shores of these States. A ship or aircraft, even of American registry, is not considered to constitute American territory when it is not within or above the land area or territorial waters of the United States.

An item of medical equipment furnished to an enrollee while he is outside the United States would be excluded from coverage, even though the item is purchased from an American firm located in the United States. The important factor in this situation is the enrollee's geographic location when he received the item rather than the location of the supplier within or outside the United States.

232.5 Services Resulting From War.--Items and services which are required as a result of war, or of an act of war, occurring after the effective date of the patient's current coverage are not covered.

232.6 Personal Comfort Items.--Items which do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member are not covered.

Charges for special items requested by the patient such as radio, television, telephone, and air conditioner, and beauty and barber services are excluded from coverage. The patient may be charged for such a service where he requested it with knowledge that he would be charged. To avoid misunderstanding and disputes, the agency will inform the individual when he requests such an item or service that there will be a specified charge (not exceeding its customary charge) and may not thereafter charge him more for the item or service than the charge specified.

232.7 Routine Services and Appliances.--Routine physical checkups; eyeglasses, contact lenses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses; eye refractions by whatever practitioner and for whatever purpose performed (effective January 2, 1968); hearing aids and examinations for hearing aids; and immunizations are not covered.

The routine physical checkup exclusion applies to (a) examinations performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury; and (b) examinations required by third parties such as insurance companies, business establishments, or Government agencies.

The exclusions apply to eyeglasses or contact lenses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses for refractive errors. The exclusions do not apply to physicians' services (and services incident to a physicians' service) performed in conjunction with an eye disease, as for example, glaucoma or cataracts, or to postsurgical prosthetic lenses which are customarily used during convalescence from eye surgery in which the lens of the eye was removed, or to permanent prosthetic lenses required by an individual lacking the organic lens of the eye, whether by surgical removal or congenital disease. Such prosthetic lens is a replacement for an internal body organ—the lens of the eye.

Expenses for all refractive procedures, whether performed by an ophthalmologist (or any other physician) or an optometrist and without regard to the reason for performance of the refraction, are excluded from coverage.

Vaccinations or inoculations are excluded as "immunizations" unless they are directly related to the treatment of an injury or direct exposure such as antirabies treatment, tetanus antitoxin, or booster vaccine, botulin antitoxin, antivenin or immune globulin.

232.8 Supportive Devices for Feet.—Orthopedic shoes or other supportive devices for the feet are not covered. The exclusion of orthopedic shoes does not apply to such a shoe if it is an integral part of a leg brace.

232.9 Excluded Foot Care Services.—The scope of covered foot care services excludes the following:

A. Treatment of Flat Foot.—The term "flat foot" is defined as a condition in which one or more arches in the foot have flattened out. Services directed toward the care or correction of such condition are not covered. (See § 232.8 for supportive devices.)

B. Treatment of Subluxations of the Foot.—Subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments or muscles of the foot.

Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered.

Reasonable and necessary diagnosis and treatment (except by the use of orthopedic shoes or other supportive devices for the foot) of symptomatic conditions, such as ostearthritis, bursitis (including bunion), tendinitis, etc.) that result from or are associated with partial displacement of foot structures are covered services. Surgical correction of a subluxated foot structure that is an integral part of the treatment of a foot injury, or that is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition, is a covered service.

This exclusion does not apply to the ankle joint (talo-crural joint).

C. Routine Foot Care.—Routine foot care includes the cutting or removal of corns, or calluses, the trimming of nails (including mycotic nails) and other hygienic and preventive maintenance care in the realm of self-care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients, and any services performed in the absence of localized illness, injury or symptoms involving the foot. For example, foot care such as routine soaking and application of topical medication on the physician's order between required visits to the physician is not covered. In addition, any treatment of a fungal (mycotic) infection of the toenail is considered routine and not covered in the absence of (1) clinical evidence of mycosis of the toenail, and (2) compelling medical evidence documenting that the patient either (A) has a marked limitation of ambulation requiring active treatment of the foot, or (B) in the case of a nonambulatory patient has a condition that is likely to result in significant medical complications in the absence of such treatment.

NOTE: Effective July 1, 1981 the treatment of warts (including plantar warts) is no longer considered routine foot care. As a result, services provided for the treatment of warts on the foot are covered to the same extent as services provided for the treatment of warts located elsewhere on the body.

The nonprofessional performance of certain foot care procedures otherwise considered routine, such as cutting or removal of corns, calluses, or nails, can present a hazard to individuals with certain disease processes. If such procedure does present a hazard to the beneficiary, it will not be considered routine when he is under the care of a doctor of medicine or osteopathy for a metabolic disease, such as diabetes mellitus, or for other conditions that have resulted in circulatory embarrassment or areas of desensitization in the legs or feet.

Services ordinarily considered routine may also be covered if they are performed as a necessary and integral part of otherwise covered services; such as diagnosis and treatment of diabetic ulcers, wounds, and infections.

232.10 Custodial Care.—Custodial care is excluded from coverage under Medicare.

232.11 Cosmetic Surgery.—Cosmetic surgery or expenses incurred in connection with such surgery is not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury, or for the improvement of the functioning of a malformed body member. For example, this inclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident, or to surgery for therapeutic purposes which coincidentally also serves some cosmetic purpose.

232.12 Charges Imposed by Immediate Relatives of the Patient or Members of His Household.—

A. General.—Payment may not be made for expenses which constitute charges by immediate relatives of the beneficiary or by members of his household. The intent of this exclusion is to bar Medicare payment for personal services of physicians or suppliers which would ordinarily be furnished gratuitously because of the relationship of the beneficiary to the person imposing the charge. Payment may be made, however, for reasonable charges imposed on such individuals by a physician or supplier to recover out-of-pocket expenses he has incurred in furnishing covered items or supplies, e.g., expenses for covered drugs and biologicals, prosthetic devices, etc. In such cases, the charge may not exceed the physician's or supplier's actual out-of-pocket costs.

B. Services of Providers and Provider-Based Physicians.—This exclusion applies only to services reimbursed on a charge basis and does not apply to provider services and to the services of group practice prepayment plans which are reimbursed for their costs rather than charges. Thus, reimbursement may be made for covered services furnished by a provider to an owner of the institution or to an immediate relative of an owner, or a member of an owner's household.

Reimbursement may not be made, however, for the professional component of services of provider-based physicians furnished to an immediate relative of the physician or to a member of the physician's household. Since the personal services of provider-based physicians are billed on a charge basis, they would be subject to this exclusion whether the bill is submitted by the physician or, with his authorization, by the provider.

C. Immediate Relative.—The following degrees of relationship are included within the definition of "immediate relative": (1) husband and wife; (2) natural parent, child, and sibling; (3) adopted child and adoptive parent; (4) stepparent, stepchild, stepbrother, and stepsister; (5) father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; (6) grandparent and grandchild.

NOTE: It has been deemed for program purposes that a brother-in-law or sister-in-law relationship does not exist between a physician (or supplier) and the spouse of his wife's (husband's) brother or sister.

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A father-in-law or mother-in-law relationship does not exist between a physician and his spouse's stepfather or stepmother.

D. Members of the Patient's Household.-- These are persons sharing a common abode with the patient as part of a single family unit, including those related by blood, marriage or adoption, domestic employees and others who live together as part of a single family unit. A mere roomer or boarder is not included.

E. Charges by Professional Corporation or Business Organization Such as Supplier and Clinic.-- Charges imposed by a medical group, clinic, or supplier which is not a corporation are, in effect, imposed by the owner or owners of the business. Thus, this exclusion applies where such a firm is owned by a sole proprietor who bears one of the excluded relationships to the patient. In the case of a partnership, the exclusion applies only where all of the partners bear one of the excluded relationships to the patient. Charges imposed by a corporation are not subject to this exclusion except in the case of charges imposed by a professional corporation for items or services furnished (1) by an owner who bears one of the excluded relationships to the patient or (2) by an employee under the supervision of a related owner. "Professional corporation" means a corporation that is operated solely for the purpose of conducting the practice of medicine, osteopathy, dentistry, podiatry, optometry, or chiropractic. Only members of the profession can own stock in a professional corporation. Any physician or group of physicians which is incorporated constitutes a professional corporation. (Generally, physicians who are incorporated identify themselves by adding letters such as P.C. or P.A. after their title.)

The exclusion does not apply to charges imposed by a corporation other than a professional corporation, regardless of the patient's relationship to any of the stockholders of the corporation or to the person who furnished the service.

232.13 Dental Services Exclusion.-- Items and services in connection with the care, treatment, filling, removal, or replacement of teeth, or structures directly supporting the teeth are not covered. "Structures directly supporting the teeth" means the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum, and alveolar process.

Payment may be made, however, for (a) surgery related to the jaw or any structure contiguous to the jaw, or (b) the reduction of any fracture of the jaw or any facial bone, including dental splints or other appliances used for this purpose. In general, "the jaw or any structure contiguous to the jaw" includes structures of the facial area below the eyes, e.g., mandible, teeth, gums, tongue, palate, salivary glands, sinuses, etc.

232.14 Items and Services under a Workers' Compensation Law.-- Items and services to the extent that payment has been made, or can reasonably be expected to be made under a workers' compensation law or plan of the United States or a State may not be paid for by the program. Payments for items and services under the health insurance program are subject to repayment to the appropriate trust fund if notice or information is received that payment has been made for the items and services under a workers' compensation plan. (See §§ 250ff.)

(Page No. 241 is not used.)

Filing for Payment

233. FILING A REQUEST FOR PAYMENT AND CLAIM FOR PAYMENT

Medicare payment of reasonable costs may not be made for provider services furnished under Part A or Part B, unles the beneficiary or his representative files a timely written request for payment and the provider files a timely claim. (See §§ 235-239.4 for an explanation of time limits.)

The home health agency should ask the patient to complete the request for payment at the time the covered services begin, if he is or may be a Medicare beneficiary, i.e., he is at least age 65 or there is other reason to believe he may be a beneficiary. If the beneficiary does not file his request upon start of care, he may file it later with the HHA. Once the patient or his representative has filed his request for payment with the HHA, the HHA must file a claim for payment (billing) with its intermediary. (See § 236 for HHA and beneficiary liability where a claim is not filed timely.)

An HHA has filed a claim for an item or service reimbursable on a cost basis if it submits to its intermediary a HCFA billing form that includes the item or service.

233.1 Establishing Date of Filing a Claim for Payment.-- Whenever the last day for timely filing of a claim for payment falls on a Saturday, Sunday, legal holiday, or other day all or part of which is a non-workday for Federal employees because of Federal statute or executive order, the claim will be considered timely if it is filed on the next workday.

233.2 Use of Postmark to Establish Filing Date of a Claim for Payment.-- Where a claim is submitted by mail, the claim can be considered filed on the day the envelope was postmarked in the United States.

234. REQUEST FOR PAYMENT

234.1 Billing Form as Request for Payment.-- Each of the billing forms (Provider Billing for Medical and Other Health Services, Form HCFA-1483; Home Health Agency Report and Billing, Form HCFA-1487; HCFA-1450 (UB82); and Request for Medicare Payment, Form HCFA-1490) contains a patient's signature line incorporating the patient's request for payment of benefits, authorization to release information, and assignment of benefits. When the billing form is used as the request for payment, it must be signed. (See § 234.2 for request on agency records.) The request for payment will then be forwarded to the intermediary (Part B carrier in the case of the HCFA-1490) or to HCFA where the provider deals directly with the Government.

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When the home health agency billing form is used as the request for payment, a single signed request ordinarily suffices for each plan. However, a subsequent signed request for payment is required if the patient's care is transferred from one home health agency to another.

234.2 Request for Payment on Provider Record.-- In place of signatures on the billing forms, a home health agency may use a procedure under which the signature of the patient (or his representative under §234.4) on its records will serve as the request for payment for services of the agency and for physician services for which the agency is authorized to bill under §427. In the case of physician services, claims may be submitted on either an assigned or unassigned basis.

To implement the procedure, the home health agency must incorporate language to the following effect in its records:

Statement to Permit Payment of Medicare Benefits to Provider, Physicians and Patient

NAME OF BENEFICIARY	HI CLAIM NUMBER

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in (name of home health agency), including physician services. I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

The request is effective until revoked. If a patient objects to part of the request for payment, the agency should annotate the statement accordingly and notify any physician affected.

The home health agency submitting claims under this procedure indicates on the claim form that it has obtained the patient's signature, by checking the block "Signature contained in the provider record," or, if the form does not contain such a block, by entering "Patient's request for payment in file" on the patient's signature line of the claim. A physician or medical group submitting claims under this procedure indicates that the agency has obtained the patient's signature, by entering on the patient signature line of the claim, "Patient's request for payment on file in (name of home health agency)."

In using this procedure, the home health agency, physician or medical group undertakes:

1. To complete and submit promptly the appropriate Medicare billing form whenever it furnishes services to a Medicare beneficiary - even in those cases in which assignment is not accepted for the physician services.

2. To incorporate, by stamp or otherwise, information to the following effect on any bills it sends to Medicare patients: "Do not use this bill for claiming Medicare benefits. A claim has been or will be submitted to Medicare on your behalf." This requirement is necessary to prevent patients from submitting duplicate claims.

The home health agency also undertakes to make the patient signature files available for carrier and intermediary inspection on request.

The intermediary and carrier must make periodic audits of signature files selected on a random basis. The carrier may arrange with the intermediary for the latter to perform this function on its behalf.

234.4 Signature on the Request for Payment by Someone Other Than the Patient.-- If at all practical, the patient should sign the request whether on the billing form or on the provider's record at the time of start of care.

In certain circumstances, it is impractical for an individual to sign the request for payment himself because when he first receives home health services, he is incompetent, or otherwise in such condition that he cannot transact any business. In such a situation, his representative payee (i.e., a person designated by the Social Security Administration to receive monthly benefits on the patient's behalf), a relative, legal guardian, a representative of an institution (other than the agency) usually responsible for his care, or a representative of a governmental entity providing welfare assistance, if present at time of start of services, should be asked to sign on behalf of the individual.

A. Provider Signs Request.-- If, at the time of start of care, the patient cannot be asked to sign the request for payment and there is no person present exercising responsibility for him, an authorized official of the agency may sign the request. However, the agency should not routinely sign the request on behalf of any patient. If experience reveals an unusual frequency of such agency-filed requests from a particular agency, the matter will be subject to review by the intermediary.

If it is impractical to obtain the patient's signature because a home health agency does not make a visit to his home (e.g., the physician certifies that the patient needs a certain item of durable medical equiment but no visits are certified), the agency may furnish the equipment and need not obtain the patient's signature. An agency representative should sign on behalf of the patient and write in Item 12 of the HCFA-1483 "Patient not visited."

B. Patient Dies Before Signing Request for Payment.-- If the patient dies before the request for payment is signed, it may be signed by the legal representative of his estate, or by any of the persons or institutions (including an authorized official of the agency) who could have signed it had he been alive and incompetent.

C. Need for Explanation of Signer's Relationship to Patient.-- When someone other than the patient signs the request for payment, the signer will submit a brief statement explaining his relationship to the patient and the circumstances which made it impracticable for the patient to sign. The agency will forward this statement with its billing, or retain it in its files if the signature is obtained on the agency's own record.

234.5 Refusal by Patient to Request Payment under the Program.-- A patient may refuse to request Medicare payment and agree to pay for his services out of his own funds or from other insurance. Such patients may have a philosophical objection to Medicare or may feel that they will receive better care if they pay for services themselves or they are paid for under some other insurance policy. The patient's impression that another insurer will pay for the services may or may not be correct, as some contracts expressly disclaim liability for services covered under Medicare. Where the patient refuses to request Medicare payment, the agency should obtain his signed statement of refusal wherever possible. If the patient (or his representative) is unwilling to sign, the agency should record that the patient refused to file a request for payment but was unwilling to sign the statement of refusal.

In any event, there is no provision which requires a patient to have covered services he receives paid for under Medicare if he refuses to request payment. Therefore, an agency may bill an insured patient who positively and voluntarily declines to request Medicare payment. However, if such a person subsequently changes his mind (because he finds his other insurance will not pay or for another reason) and requests payment under the health insurance program within the prescribed time limit, the agency must bill the intermediary. The agency should then refund to the patient any amounts he paid in excess of the permissible charges.

Where a patient who has declined to request payment dies, his right to request payment may be exercised by the legal representative of his estate, by any of the persons or institutions mentioned in section 234.4B by a person or institution which paid part or all of the bill, or in the event a request could not otherwise be obtained, by an authorized official of the agency. This permits payment to the agency for services which would not otherwise be paid for and allows a refund to the estate or to a person or institution which paid the bill on behalf of the deceased.

See section 236 for effect on beneficiary and provider of refusal to file.

234.6 Data Elements Needed to Render a Home Health Coverage Determination.--Standardized data collection forms have been developed to promote more consistent coverage decisions and minimize payment for noncovered services. The HCFA-485, Home Health Certification and Plan of Treatment, contains the data required by regulation to meet the physician's plan of treatment (POT) requirements and is recognized by all intermediaries and national survey requirements for plans of treatment and certification.

The HCFA-486, Medical Update and Patient Information, contains data needed by intermediaries to make coverage determinations on home health claims. The HCFA-487, Addendum to The Plan of Treatment/Medical Update and Patient Information, may be used by home health agencies to provide additional documentation of any elements on the HCFA-485/486. The HCFA-488, Intermediary Medical Information Request, contains supplemental data which may be required on a case by case basis where the HCFA-485, 486, and/or 487 do not provide sufficient information for a payment decision. Only the HCFA-485/486/487 may be required by intermediaries for use as medical information forms; all other home health forms are obsolete.

HCFA requires home health agencies to submit the HCFA-485/486 with the initial claim and with the claim closest to the recertification date thereafter. For example, if a patient has a start of care of 9/14/85, submit a completed HCFA-485/486 with the claim for services 9/14-9/30/85 and with a claim for services rendered 11/1-11/30/85, if the patient was recertified for services after 11/14/85.

Where the information on the HCFA-485/486/487 is not sufficient to make a coverage decision, the HCFA-488 is used to request additional information and/or the medical record. The HCFA-488 is also used to request medical information on interim claims which require development prior to payment because the HCFA-485/486 were not required to be submitted.

Routine submission of medical information more frequently than every 60 days (e.g., every 30 days) may be required at the discretion of the intermediary. However, you will be asked to complete only items 1 through 7, items 10 through 15, and item 22 of the HCFA-486 and submit it with the interim claim. (The intermediary may request that a photocopy of the current plan of treatment (HCFA-485) be attached to the HCFA-486 on interim bills.)

Routine submission of medical records will be requested with the claims only when absolutely necessary (e.g. the agency has been identified as a poor performer based on denial statistics or coverage compliance review results). Specific medical records may be requested where diagnoses, services or situations are identified which require intensified review. For example, when the HCFA-485 does not provide adequate documentation of the skilled nature of the nursing care, the medical records must be obtained and reviewed to determine whether the skilled nursing service meets Medicare guidelines. In other situations, where neither the diagnosis nor the HCFA-485/486 information supports a definitive determination of the homebound status, the medical record will be used to determine payment.

Providers who submit claims via electronic media are required to send the medical information data with the initial claim and with each bill closest to the recertification date. Specifications for electronic transmission of HCFA-485/486/487 are contained in addenda A and D of the Home Health Manual. Retain the hard copy version of the form and submit it to the intermediary upon request.

The intermediary may deny visits/services on the basis of the information found on the forms. You need not request medical records before denying visits/services. The intermediary will not arbitrarily deny a claim because you failed to complete all items on the HCFA-485/486. Complete the forms by placing "not available" in the item for which there is no information available so that the intermediary will know that an item is blank because the information is not available. If the item which is blank is important to a coverage decision, the intermediary should request the information from the provider prior to processing the claim. If the item is blank because you do not have the information and the information is vital (e.g., services ordered by the physician), the case will be denied.

234.7 **HCFA-485 - Home Health Certification and Plan of Treatment Data Elements**.--The HCFA-485, Home Health Certification and Plan of Treatment, is designed to meet the regulatory requirements (State and Federal) for both the physician's home health plan of treatment and home health certification and recertification requirements. You are required to submit a completed HCFA-485 with each beneficiary's initial claim and with each claim closest to the beneficiary's recertification date thereafter. For example, as indicated in Section 3902A, if a patient has a start of care of 9/14/85, you must submit a completed HCFA-485 (and HCFA-486) with the first claim for the services rendered from 9/14 to 9/30/85. You must submit a completed HCFA-485 (and HCFA-486) again with the claim for services rendered 11/1 to 11/30/85, if the patient was recertified for home health services after 11/14/85. The HCFA-485 submitted with the claim for services is the physician recertification.

The form must be completed in its entirety and must be signed and dated by the physician. However, as noted in Section 234.6, the intermediary may not arbitrarily deny visits/services because you did not complete all of the items. If you leave an item blank that is important to a coverage determination, the intermediary should request the information from you via the HCFA-488 prior to adjudicating the claim.

The following elements are contained on the HCFA-485:

1. **Patient's Name and Address**

Enter last name, first name, street address, city, state and zip code.

2. **Patient's HI Claim Number**

Enter the health insurance claim (HIC) number as shown on the patient's health insurance card, certificate award, utilization notice, temporary eligibility notice, or as reported by the Social Security Office (numeric plus alpha indicator(s)).

3. Medical Record Number

Enter the patient's medical record number as assigned by you . This item is solely for your convenience and use. You are not required to complete this item. However, the medical record number may facilitate your identification of patient records for response to intermediary requests for medical records.

Home health agencies that do not use medical record numbers are required to place N/A (not applicable) in this space. Intermediaries are not required to review this item.

4. Dates: Start of Care and Verbal Order for SOC

Enter the 6 digit month, day, year on which covered home health services actually began, i.e., MM DD YY (070484). This date will remain the same on subsequent plans of treatment until the patient is discharged by the agency. Note the date the agency received verbal orders from the physician, only if these are prior to the start of care date.

5. Certification Period

Enter the 6 digit month, day, year date, i.e., MM DD YY (070484-090484), which identifies the period covered by the physician's plan of treatment for this patient. The "From" date should be the first day of the certification period. The "To" date may be up to but not exceed 60 days after the "From" date. The certification period will incorporate but may not match the billing period.

6. Home Health Agency Name and Address

Enter the provider name or branch office, street address, city, state and zip code. (Note: This item was placed to facilitate the use of a window envelope.)

7. Principal Diagnosis, - Narrative, Dates of Onset/Exacerbation, ICD-9-CM Code

The principal diagnosis must be entered on all HCFA-485 forms. The principal diagnosis is the diagnosis most related to the current plan of tretment. The principal diagnosis may or may not be related to the patient's most recent hospital stay, but must relate to the services rendered by the home health agency. If more than one diagnosis is treated concurrently, the diagnosis that represents the most acute condition and requires the most intensive services should be entered.

The principal diagnosis should only change on subsequent forms if the patient develops a subsequent acute condition requiring intensive services different than the established plan of treatment. For example, a patient with a recent fractured hip and congestive heart failure of long standing would have a principal diagnosis of fractured hip and a secondary diagnosis of congestive heart failure. However, if two weeks later, the patient develops acute congestive heart failure requiring hospitalization and follow-up home health care, at the point the patient is picked up for home care, the recertification plan of treatment would list acute congestive heart failure as the principal diagnosis and fractured hip as a secondary diagnosis.

The narrative description for the one principal diagnosis should be present, followed by the date of onset and the date of exacerbation (acute recurrence), if different from the date of onset. Each date should be as close to the actual date as possible. At a mininimum, the month and year for date of onset and/or exacerbation should be present, i.e., MM OO YY (060084).

Enter the appropriate ICD-9-CM code for the principal diagnosis in the blocks provided on the form. The code must be the full ICD-9-CM diagnosis code including all 5-digit codes.

8. Surgical Procedure(s) Relevant to Care: Narrative, Date, ICD-9-CM Code

Enter the surgical procedure(s) relevant to the care being rendered. For example, if the diagnosis in item number 7 is "Fractured Left hip" 060984, the surgical procedure and date (Austin Moore Prothesis 060984) should be noted. If no surgical procedure was either performed or is relevant to the plan of care, this item should remain blank by placing N/A (not applicable) in this space. Also list ICD-9-CM codes for the surgical procedure. Use the addendum (HCFA-487) for additional relevant surgical procedures. At a minimum, the month and year should be present for date of surgery, i.e., MM OO YY (060084).

9. Other Pertinent Diagnoses-Dates of Onset/Exacerbation, ICD-9-CM Code

Enter all pertinent diagnoses, both narrative and ICD-9-CM Codes, which are relevent to the care being rendered. Other pertinent diagnoses are all conditions that coexist at the time the plan of treatment is established or develop subsequently. Exclude diagnoses that relate to an earlier episode which have no bearing on this plan of treatment. Note the date of onset/exacerbation for each diagnosis as close to the actual date as possible (for example, month, day, year). If specific date is unknown, at least note the year of onset/exacerbation. If more than the four other diagnoses noted on the UB-82 billing form (1450) are needed for the plan of treatment, use the addendum (HCFA-487) to list the additional conditions.

10. **Functional Limitations and Activities Permitted**

Functional limitations - these items reflect the physician's assessment of the patient's functional limitations. Indicate all items which describe the patient's current limitations as assessed by the physician.

Activities permitted - Indicate the activity(ies) which the physician allows the patient to perform and/or for which physician orders are present.

If "Other" is checked under either category, provide a narrative explanation. Use the addendum (HCFA-487) if necessary.

11. **Safety Measures**

The physician's instructions for safety measures should be listed in this item.

12. **Orders for Services and Treatment (Specify modality, amt/freq/dura)**

Physician's orders for the type of service to be rendered: duties/treatments to be performed by each service including the frequency and duration for each service. Type of services may be one or more of the following: skilled nursing (SN), physical therapy (PT), speech therapy (ST), occupational therapy (OT), medical social service (MSS), home health aide (AIDE) or other services, i.e., nutritionist, male orderly, respiratory therapist, etc. Orders for type of service must include all services the physician requests for the patient even if some types of services may not be billed to the Medicare program. Where services (SN, PT, ST, OT, MS, AIDE) are ordered, the plan of treatment must include the specific services/modalities to be rendered. Use the addendum (HCFA-487) for additional space as needed.

Frequency of visits must be specified by the physician as needed to render the necessary care. Frequency denotes the number of visits per service to be rendered and should be stated in days, weeks, or months. Duration should identify the length of time the services are to be rendered and may be expressed in days, weeks or months.

Modality refers to the specific services to be rendered by physical, speech and occupational therapists. For example, PT may render gait training, active assistance exercises and transfer training. Each of these modalities must be listed under physician's orders.

Amount refers to the length of time per modality or treatment, e.g. hot packs x 10 minutes.

13. Medications: Dose/Frequency/Route

The physician's orders for all medications including the dose, frequency and route of administration for each drug must be listed. Use the addendum (HCFA-487) for drugs which cannot be listed on the plan of treatment. Use the letter "N" after the medication(s) which are "new" orders and the letter "C" after the medication(s) which are "change" orders either in dose, frequency or route of administration. "New" orders refer to medications which the patient has not taken recently, i.e., within the last 30 days, or which the patient has never taken prior to this time. Change orders for medications include dosage changes, frequency changes or route of administration changes within the last 60 days. Providers that submit electronically, refer to Addendum D (Medications), Chapter 4.

NOTE: Any problems with ineffective drug therapy, adverse reactions, significant side effects, contraindicated medications, and drug allergies are to be promptly reported to the physician by the home health agency.

14. Mental Status

Physician should check the block(s) most appropriate to describe the patient's mental status. If "Other" is checked please specify condition.

15. Nutritional Requirements

Physician's order for the diet. This includes specific therapeutic diets and/or any specific dietary requirements. Fluid needs or restrictions should also be recorded in this item.

16. Medical Supplies and DME Ordered

The physician should specify the type of supplies necessary for the agency to carry out the physician orders. List all supplies which may be considered nonroutine agency supplies and, therefore, are billed to Medicare when used.

For example, dressing changes may require use of peroxide, 4 x 4's, telfa pads, kling and non allergic tape. Catheter changes may require catheter kit and irrigation kit as well as irrigating solutions. Agencies do not need to list the exact amount of usage but must note the types of supplies to be used. List the type of durable medical equipment (DME) ordered by the physician for the patient that will be billed by the agency. Place a "B" to the right of any equipment which will be billed by the agency.

17. Allergies

Medications to which the patient is allergic should be listed in the area provided for this item. In addition, other allergies the patient experiences (e.g., foods, adhesive tape, iodine) are to be listed.

18. Goals/Rehabilitation Potential/Discharge Plans

Physician should specify the goals, rehabilitation potential and discharge plans to be accomplished for this patient. Some examples of potential goals could be:

a. Non-chronic illness - return to pre-illness functioning;

b. Early stage chronic illness - potential to return to pre-episodic level;

c. Intermediate stage chronic illness or advanced stage - will eventually function without agency services;

d. Advanced stage chronic illness - manage only with emergency assistance;

e. End stage illness - manage only with emergency assistance.

f. Compliance with medication/diet;

g. Ambulation without assistance.

Rehabilitation potential should address the patient's ability to attain the goals set forth by the physician and agency and should reflect the actual predictability of the patient to accomplish these goals. This information should be pertinent to nature of patient's condition and ability to respond. For example, rehabilitation potential good for partial return to previous level of care, but patient will probably not be able to perform activities of daily living (ADLs) independently.

Discharge plans should include either a statement of where or how the patient will be cared for once home health services are no longer provided or whether the patient will return to an independent level of care.

19. Significant Clinical Findings/Summary From Each Discipline

Home health agency personnel must enter a narrative description of the clinical findings of the patient. For the initial certification period this information will usually reflect the patient assessment during the evaluation visit and should include the patient's vital signs and a narrative description of the patient's symptoms. For recertification periods, the agency should provide updated information which incorporates current vital signs and symptoms and changes in the patient's condition during the last 60 days of service, including progress or non-progress for each discipline. This information should provide the physician with a clear picture of what has occurred during the last 60 days. Use addendum (HCFA-487) for elaboration. Providers who submit electronically are required to complete this item on the hard copy HCFA-485 form.

20. Prognosis

Physician should place a check in the box which specifies the most appropriate prognosis for the patient; poor, guarded, good or excellent.

21. Attending Physician's Name and Address

Enter the attending physician's name and address. (NOTE: this has been placed to facilitate the use of a window envelope.) The attending physician is the physician who established the plan of tretment and who certifies and recertifies the medical necessity of the home health visits and/or services.

22. Physician Certification

The attending physician checks whether this is an initial certification or recertification.

23. Attending Physician's Signature and Date

The attending/referring physician is required to sign and date the plan of treatment/certification, HCFA-485, prior to the claim being submitted for payment. You are required to submit a signed HCFA-485 with the initial and recertification claim. Physician's signature on the carbon copy of the HCFA-485 are considered originals. Rubber signature stamps are not acceptable.

Only providers who bill electronically are allowed to use a "signature on file" statement.

Supplemental POTs by specialists should be kept with the home health agency medical records, and their existence should be noted in item 20 of the HCFA-486.

234.8 HCFA-486 - Medical Update and Patient Information.--The HCFA-486, Medical Update and Patient Information, contains data needed by intermediaries to make coverage determinations on home health claims. You are required to submit a completed HCFA-486 with each beneficiary's initial claim and with each subsequent claim closest to the beneficiary's recertification date thereafter. For example, as indicated in Section 234.6, if a patient has a start of care date of 9/14/85, you must submit a completed HCFA-486 (and HCFA-485) with the first claim for services rendered from 9/14 to 9/30/85. You must submit a completed HCFA-486 (and HCFA-485) again with the claim for services rendered 11/1 to 11/30/85, if the patient was recertified for home health services after 11/14/85.

The form must be completed in its entirety. However, as noted in Section 234.6, the intermediary may not arbitrarily deny visits/services because you did not complete all the items. If you leave an item blank, or indicate N/A (not applicable) in an item that is important to a coverage determination, the intermediary should request the information from you via the HCFA-488 (see Section 234.11) prior to adjudicating the claim.

The intermediary may require that you submit an updated HCFA-486 with interim claims which require development prior to adjudication. These interim claims are those claims where you are not required to submit the HCFA-485 and HCFA-486. For example, the patient's start of care and initial certification date is 9/14/85. The home health agency is required to submit completed HCFA-485 and HCFA-486 for services provided from 9/14 to 9/30/85. However, if you continue services during October, you are not required to submit the forms. This claim is referred to as the interim claim.

Where the intermediary requests an updated HCFA-486 from you on an interim claim, you are only required to complete the following items:

item 1 - Patient's name
item 2 - HIC no.
item 3 - Sex
item 4 - Date of birth
item 5 - Medicare covered
item 6 - Period covered or certification period
item 7 - Provider name and number
item 10 - Date and reason agency last contacted physican
item 11 - Is the patient receiving additional medically reasonable and necessary skilled care pursuant to a physician's plan of treatment paid for by other than Medicare?
item 12 - Dates of last inpatient stay/Type of Facility
item 13 - Date physician last saw patient
item 14 - Specific Services and Treatments (Codes on Reverse)
item 15 - Updated information: New orders/Treatments/Clinical facts
item 22 - Signature of nurse or therapist completing or reviewing form/date

The following elements are contained on the HCFA-486. The elements are completed by the home health agency. The completed HCFA-486 must be signed and dated by the nurse or therapist reasponsible for the completion of the form or a nonclerical agency representative or supervisor responsible for the review of the form (see Section 234.8, item 22).

1. Patient's Name

Enter last name, first name.

2. HIC No

Enter the health insurance claim (HIC) number as shown on the patient's health insurance card, certificate award, utilization notice, temporary eligibility notice, or as reported by the Social Security Office (numberic plus alpha indicator(s)).

3. Sex

Check appropriate box.

4. Date of Birth

Enter the date (6 digit month, day, year) in numerics, i.e., MM DD YY (040120).

5. Medicare Covered

Check appropriate box. Noncovered would be checked when the information is submitted "at the patient's request" or to establish Medicaid eligibility.

6. Period Covered or Certification Period

Enter the 6 digit month, day, year; i.e., MM DD YY (060784), which identifies the period covered by the physician's plan of treatment for this patient. The "From" date should be the first day of the certification period. The "To" date may be up to but not to exceed 60 days after the "From" date. The certification period will incorporate but may not match the billing period.

7. Provider Name and Number

Enter the agency name, or branch office if applicable and the assigned provider number.

8. Place of Treatment, if Other Than Home - Name and Address

A requirement for eligibility for the home health benefit is that services be provided at the patient's residence. If care is provided at other than the patient's home or the home of a friend or relative (continuously), enter the name of the place of residence and the address. If the patient is residing in a nursing home which meets at least the requirements of Section 1861(J)(1), that facility cannot be considered the patient's residence.

9. Are Services Related to Any Accident or Employment Related Injury?

Check the appropriate box to indicate that an insurer other than Medicare may be the primary payor. This area applies to accidents where liability may reside with an entity or individual responsible for the incident, e.g.

automobile accident. This question also applies to services which may be covered by insurance available to the beneficiary through employment, including a spouse's employment. This item is not intended as a medical review function. This information is to assist intermediaries in identifying potential Medicare supplemental payor claims.

10. Date and Reason Agency Last Contacted Physician

Note the date MM DD YY (080485) of the agency's most recent physician contact (verbal or written) regarding the status or problems encountered with the patient during the last 60 days. Briefly state the purpose of your contact. Use the HCFA-487 addendum for additional space.

11. Is the Patient Receiving Additional Medically Reasonable and Necessary Skilled Care Pursuant to a Physician's Plan of Treatment Paid for by Other than Medicare?

Check the appropriate block, yes or no. If the response is yes, specify what the additional services are, the frequency and who is assuming responsibility for their payment. This does not pertain to custodial, maintenance or respite care, regardless of who is delivering the services and regardless of payor source. If yes, the intermediary should request records to determine whether the intermittent requirements are met. Examples of medically necessary and reasonable care include skilled nursing visits and/or home health aide visits which the physician orders but are not billed to Medicare.

12. Dates of Last Inpatient Stay - Type of Facility

Enter the "From and To" dates (month, day and year (060285-061085)) of the last inpatient stay relevant to the care currently being provided. Identify the type of facility (e.g., acute, SNF, rehabilitation) if discharge was within 60 days of the start of care date. On recertification list any intervening stay(s).

13. Date Physician Last Saw Patient

Complete this item if information can be obtained from the patient or the family during the home visit. If the provider is unable to determine the last time the patient was seen by the physician enter N/A (not applicable). Note: it is not intended that the agency contact the physician's office to account for patient's visits. Physician visits of less than once every 60 days raises a question as to whether the patient requires a level of care which qualifies him/her for home benefits. Intermediaries will carefully evaluate the patient's entire medical condition before denying visits because physician visits are less than every 60 days.

14. Specific Services and Treatments (Codes on Reverse)

Enter current data relative to services and treatment ordered on the plan of treatment (HCFA-485). Include any changes in frequency and duration and the addition of new services which occurred after the plan of treatment was established and are listed in item 15 of this form.

Total visits are the total visits for each service projected over the 60 day period represented on the plan of treatment. For example, nursing visits 3 x week x 2 weeks then 2 x week x 6 weeks, total 18 nursing visits. Each discipline should have one total number for that service.

Services refer to the discipline ordered, e.g., SN, PT, ST, OT, MSW, AIDE. Service orders should be grouped together if they occur at the same frequency. For example, if a discipline performs two or more services on the same visit, the treatment orders can be combined in one space. List the service that corresponds to each column across the line. Treatment codes must correspond to the service noted on that line.

Claims which span either an initial certification and a recertification period or two recertification periods require specific information in item 14 (HCFA-486) regarding the actual number of visits rendered prior to the recertification period. Where the "From" date in item 6 of the HCFA-486 is later than the "From" date on the claim, the provider must identify and list the number of visits rendered between the last billed period and the new recertification period. This information should be shown in item 14 in the "Services" column in parenthesis following the service code. For example, a claim for 11/01/85 to 11/30/85, with a start of care/certification date of 9/14/85, will require a HCFA-485/486 attachment for the recertification period 11/14/85 to 1/14/86. In this case, item 14 - "Services" column must contain the total number of visits per service type rendered from 11/1/85 to 11/13/85 only. In this example, if the agency bills for 10 skilled nursing visits, of which 4 visits were rendered between 11/1/85 and 11/13/85, then the Service column in item 14 of the HCFA-486 will contain SN (4). If more than one service (i.e., discipline) renders visits prior to the recertification period, then the agency will note the number of visits for each service.

Specific Treatment Orders - The home health agency must transcribe the treatments ordered by the physician on the HCFA-485 to this space. This information should reflect the services as shown in number 12 on the plan of treatment (HCFA-485). These orders will then be reflected by a corresonding treatment code across the line.

Frequency and duration should identify the proposed frequency and duration related to the specific treatment order. Orders for changing frequencies and durations over the projected 60 day period should also be shown here, e.g., skilled observation 3 X a week X 4 weeks, then 2 X a week X 4 weeks.

Frequency and duration must consistently be expressed in like terms. Where frequency is noted in days, weeks, or months, then duration must also be shown as days, weeks, or months respectively. Frequency and duration will be expressed in days (da), weeks (wk), or month (mo), in 3 digits as follows:

3 X week X 6 weeks = 3 wk 6
1 X day X 2 weeks (14 days) = 1 da 14
1 X month X 2 month = 1 mo 2
1 X every 90 days = 1 q 90

Tx Code - Enter treatment codes chosen from the list on the back of the medical information form which will identify the services the home health agency provides. Refer to Section 3902.3 for definitions of the treatment codes.

More than one treatment code may be listed on a line, however, each treatment code must be listed separately, i.e., A1 A2 A3. Codes may not be lumped together, e.g., A1-3.

Treatment codes include specific alpha designators for each service. Skilled nursing codes are designated by the alpha "A." Appropriate codes must be used to identify corresponding services across the line. For example, physical therapy (B) codes may not be listed on the same line as skilled nursing (A) codes.

Tot. Vs.	Serv.	Orders	Freq./Dura.	Tx Codes
60	SN	Observation, Teach Diabetic Care	3 WK 4	A1 A25
	SN	Prep Insulin, Teach Adm Inj	1 DA 60	A12 A24

Do not automatically deny a claim because the codes are not completed.

15. Updated Information: New Orders/Treatments/Clinical Facts

Describe new orders or treatments which may have been added or changed subsequent to the initial information supplied for up to the 60 day period represented by the POT. Additionally, new clinical facts based on the agency's skilled observations of the patient should be included. Also indicate how new orders come about (e.g., nurse observed, phoned physician). Use the addendum page (HCFA-487) for elaboration or when new orders and/or treatments are added (other than already recorded in number 14 of the HCFA-486). This item also is to be completed when the FI requests information between certifications.

16. Functional Limitations/Rehabilitation Potential/Goals (Each Discipline)

Provide a narrative description of the functional limitations and activities permitted, elaborating on the information found in the checklist (HCFA-485 item 10) and providing any other relevant information. The description of the patient's activities should clearly reflect for the reviewer the restrictions imposed by the physician. Include a description of ADL limitations and indicate the type and scope of assistance needed. Each discipline also should comment on the rehabilitation potential and the therapeutic goals.

17. Homebound

A. Reason Homebound - Narrative:

Include a brief statement of why the patient is homebound. Include a description of the home environment, if that description is relevant to the homebound determination, e.g., patient lives in a third floor walk-up apartment and recovering from congestive heart failure.

B. Indicate any times when the Home Health Agency made a visit(s) and the patient was not home and reason why if ascertainable.

Include a statement of when this occurred and an explanation of why. For example: 01/31/84 - Patient was taken to the emergency room for evaluation and treatment after a fall in her home.

C. Specify any known medical and/or non-medical reasons the patient regularly leaves home and frequency of occurrence.

Obtain information from the patient, family or caretaker on patient's absences from the home and whether they are for medical or non-medical reasons. For example, the patient goes to the barber shop 1 X a month and to the doctor's 2 X a month.

18. Is there an available, able and willing care giver?

Check the appropriate box. If the response is yes, indicate clearly what the caretaker is able and willing to do. Specify what care is being provided, including frequency and relationship of person providing it.

19. Unusual Home/Social Environment (Optional)

Use this block to include information which would enhance the reviewer's concept of the home situation and help to justify the need for services in the home e.g., patient lives with retarded son who is unable to provide any assistance or to comprehend instructions. The information in this item may also explain the rationale for medical social services.

20. Does your agency have any supplementary plans of treatment on file from a physician other than the referring physician or from other specialists for care being given the patient by your agency?

Provide this information if more than one plan of treatment is being used to provide services to this patient. If so, document the specialty, the type of service, duties, frequency and duration and the reasons necessitating a supplemental plan of treatment. For agencies who bill electronically, the intermediary will use the HCFA-488 when necessary to request a copy of supplemental plan of treatment.

21. Other DME Available for Use

List other equipment which is available for use in the patient's home even though this equipment will not be billed by the agency. Use the addendum for any items which cannot be listed on the plan of treatment due to lack of space.

22. Signature of Nurse or Therapist Completing or Reviewing Form/Date

The nurse or therapist responsible for the completion of the form or a nonclerical agency representative or supervisor responsible for the review should sign and date the form.

234.9 Treatment Codes for Home Health Services.--Enter the code which represents the service(s) to be rendered under the plan of treatment. The listing of a code for a particular service is not intended to imply coverage. The codes are to identify services ordered by the physician whether or not these services are reimbursable by Medicare individually.

A. Skilled Nursing (SN).-- Code all services which are to be performed by the nurse. Do not code services which the patient or other person in the home is performing without the teaching or supervision of the nurse. The following is a further explanation for each service:

A1. Skilled Observation (Inc. V.S., Response to Med., etc.) - Include all skilled observation of the patient where the physician determines that patient's condition is such that a reasonable probability exists that signficiant changes may occur which require the skills of a licensed nurse to supplement the physician's personal contacts with the patient (Section 204.4A).

A2. Foley Insertion - Insertion and/or removal of the foley catheter by nurse.

A3. Bladder Instillation - Instilling medications into the bladder.

A4. Wound Care/Dressing - Includes irrigation of wounds, application of medication and/or dressing changes. Does not include decubitus care. Describe dimension of wound (amount and type of drainage) under item 19 and under physician orders for Tx in item 12 on the HCFA-485.

A5. Decubitus Care - Includes irrigation, application of medication and/or dressing changes to decubitus. Describe size (depth and width) and appearance in item 19 and note physician's orders for treatment in item 12 of the HCFA-485. The principle indication of whether skilled care is required would be the physician's order for treating the skin rather than the patient's diagnosis. Therefore, the reviewer should review the physician's orders for treatment in item 12 of the HCFA-485.

A6. Venipuncture - Specify test and frequency to be performed under physician's orders.

A7. Restorative Nursing - Includes exercises, transfer training, carrying out of restorative program ordered by the physician. This program may or may not be established by a physical therapist. This code should not be used to describe such non-skilled services as routine range of motion exercises.

A8. Post Cataract Care - Includes observation, dressings, administration of optic medications, teaching, etc., of the immediate postoperative cataract patient. (Refer to Section 204.4A)

A9. Bowel/Bladder Training - Includes training of patients who have neurological or muscular problems or other conditions where the need for bowel or bladder training are clearly identified. (Refer to Section 204.4A)

A10. Chest Physio (Inc. postural drainage) - Includes breathing exercises, postural drainage, chest percussion, conservation techniques, etc.

A11. Adm. of Vitamin B/12 - Administration of vitamin B/12 preparation by injection for conditions identified in Medicare guidelines.

A12. Prep./Adm. Insulin - Preparation of insulin syringes for administration by the patient or other person or the actual administration of the insulin injection by the nurse.

A13. Adm. Other IM/Subq. - Administration of any injection other than vitamin B/12 or insulin ordered by the physician.

A14. Adm. IV's/Clysis - Administration of intravenous fluids or clysis or intravenous medications.

A15. Teach. Ostomy or Ileo Conduit Care - Teaching the patient or other person to care for a colostomy, ileostomy or ileoconduit or nephrostomy.

A16. Teach. Nasogastric Feeding - Teaching the patient or other person to administer nasogastric feedings. Includes teaching care of equipment, and preparation of feedings.

A17. Reinsertion Nasogastric Feeding Tube - Includes changing the tube by the nurse.

A18. Teach. Gastrostomy Feeding - Teaching the patient or other person to care for gastrostomy and administer feedings. Includes teaching care of equipment and preparation of feedings.

A19. Teach. Parenteral Nutrition - Teaching the patient and/or family to administer parenteral nutrition. Includes teaching aseptic technique for dressing changes to catheter site. Agency documentation must specify that this service is necessary and does not duplicate other teaching.

A20. Teach. Care of Trach. - Teaching the patient or other person to care for a tracheostomy. This includes care of equipment.

A21. Adm. Care of Trach. - Administration of tracheostomy care by the nurse, including changing the tracheostomy tube and care of the equipment.

A22. Teach. Inhalation Rx - Teaching patient or other person to administer therapy and care for equipment.

A23. Adm. Inhalation Rx - Administration of inhalation treatment and care of equipment by the nurse.

A24. Teach. Adm. of Injection - Teaching patient or other person to administer an injection. Does not include the administration of the injection by the nurse (see A11, A13) or the teaching of insulin administration (see A25).

A25. Teach. Diabetic Care - Includes all teaching of the diabetic patient (i.e., diet, skin care, administration of insulin, urine testing, etc.)

A26. Disimpaction/Follow-up Enema - Includes nursing services associated with removal of an impaction. Enema administration only if a complex condition exists - e.g., immediate postoperative rectal surgery.

A27. Other (Spec. under orders) - Includes any skilled nursing or teaching ordered by the physician and not identified above. Specify what is being taught in item 12 (HCFA-485).

B. Physical Therapy.--Code all services to performed by the physical therapist. If services are provided by nursing, they should be included under A7. The following is a further explanation of each service:

B1. Evaluation - Visit(s) made to determine patient's condition, physical therapy plans and patient's rehabilitation potential.

B2. Therapuetic Exercise - Exercises designed to restore function. Specific modalities should be specified in plan of treatment.

B3. Transfer Training - Teaching transfer techniques, e.g., bed to chair, chair to commode.

B4. Estab. Maintenance Prog. - Includes teaching all physical therapy services to establish a maintenance program to be carried out by patient, family member, or other responsible party.

B5. Gait Training - Includes all ambulation training of patient with a loss of gait through disability resulting in need for retraining.

B6. Chest Physiotherapy - Includes breathing and pulmonary exercises, postural drainage, etc., designed for patient with acute or severe respiratory disorder.

B7. Ultra Sound - Mechanism to produce heat in deep tissues for conditions in which relief of pain, increase in circulation and increase in local metabolic activity are desirable.

B8. Proprioceptive Neuromuscular Facilitation - A technique which utilizes existing muscle potential to increase strength and range of motion using a patterning type of exercises.

B9. Passive Exercises - Exercises accomplished by the therapist or apparatus with no active contraction of the involved part by the patient.

B10. Active Exercises - Exercises accomplished by the patient without assistance or resistance.

B11. Resistive Exercises - Active exercises accomplished by the patient with additional resistance, either manual or mechanical.

B12. Stretching Exercises - Exercises accomplished by forced motion, either passive or active.

B13. Prosthetic Training - May include stump conditioning, shrinking, shaping and range of motion prior to actual rehabilitation with the prosthesis.

B14. Whirlpool - Useful as an efficient means of conducting heat to the extremities.

B15. Other (Spec. Under Orders)- Include all physical therapy services not identified above. Specific therapy services must be identified under physician's orders (HCFA-485 item 12).

C. Speech Therapy.-- Code all services to be performed by the speech therapist. Following is a further explanation of each service.

C1. Evaluation - Visit made to determine treatment needs of patient. Includes testing, establishment of plan of treatment and identifying goals.

C2. Alaryngeal Speech - Includes any procedure or treatment designed for postoperative laryngectomy patients.

C3. Language Processing - Includes any procedure or treatment designed for patients with any speech articulation disorder (other than aphasia).

C4. Speech/Voice - Includes procedures and treatments designed for patients with problems of voice quality or voice production. Exact mode of treatment must be specified in physician orders.

C5. Comprehensive - Includes procedure or treatment designed for patients with receptive aphasia or expressive aphasia (dysphasia), language processing or language formulation disorders, apraxia of speech, dysarthria, cerebral palsy, multiple sclerosis, and other neurological communication problems related to hearing disorders.

C6. Aural Rehab. - Includes procedures or treatments designed for patients with communication problems related to hearing disorders.

C7. Other (Spec. Under Orders) - Speech therapy services not included above. Specify service to be rendered under physician's orders (HCFA-485 item 12).

D. Occupational Therapy.-- Code all services to be rendered by the occupational therapist. Following is a further explanation of the services:

D1. Evaluation - Visit made to determine occupational therapy needs of the patient. Will include testing, establishment of plan of treatment and rehabilitation goals.

D2. ADL Training - Includes all training in activities of daily living, use of special equipment for carrying out activities, etc.

D3. Muscle Re-education - Includes therapy designed to restore function lost due to disease or as a result of surgical intervention.

D4. Other (Spec. Under Orders) - Occupational therapy services not identified above. Specify therapy under doctor's orders (HCFA-485 item 12).

E. Medical Social Services.-- Code all services to be rendered by the medical social service worker. Following is a further explanation of the services:

E1. Assessment of Social and Emotional Factors - Assessment of social and emotional factors related to the patient's illness, need for care, response to treatment and adjustment to care.

E2. Counseling - Counseling services required by the patient for medical education of their condition and response to treatment.

E3. Financial Assistance - Assessment of financial factors which may affect the patient's recovery may include advice about financial affairs and/or referral to community resources.

E4. Placement Assistance - Assessment of patient's needs for continued care, including evaluation of home and family situation and assisting patient and family to make arrangements for placement.

E5. Arrange for Meals - Assessment and appropriate action to obtain community services such as meals on wheels, food stamps, etc.

E6. Other (Spec. under Orders) - Include other medical social services related to the patient's illness and his/her need for care. The service to be performed must be written under doctor's orders (HCFA-485 item 12).

F. Home Health Aide.-- Code all services to be rendered by the home health aide. Specific personal care services to be provided by the home health aide must be determined by a registered professional nurse. Services are given under the supervision of the nurse, and if appropriate, a physical, speech or occupational therapist. Following is a further explanation of the services:

F1. Tub/Shower Bath - Assistance with tub or shower bathing.

F2. Partial Bed Bath - Assisting the patient with bed bath.

F3. Complete Bed Bath - The bathing of a patient who is unable to assist.

F4. Shave Patient - Shaving of patient who is unable to perform activity.

F5. Comb Hair - Combing of hair of patient who is unable to comb own hair.

F6. Catheter Care - Care of catheter site and/or irrigations under nursing supervision.

F7. Change Linen - This service will be provided by the aide as it relates to personal care services.

F8. Assist with Ambulation - Assisting the patient with ambulation as determined necessary by the nursing care plan.

F9. Transfer Bed/Chair - Assisting the patient with transfers in accordance with the plan of treatment.

F10. Exercises - Assisting the patient with exercises in accordance with the plan of treatment.

F11. Prepare Meal - May be furnished by the aide during a visit for personal care.

F12. Grocery Shop - May be furnished as an adjunct to a visit for personal care to meet the patient's nutritional needs in order to prevent or postpone the patient's institutionalization.

F13. Wash Clothes - This service may be provided as it relates to the comfort and cleanliness of the patient and his (her) immediate environment.

F14. Housekeeping - Household services incidental to care and which do not substantially increase the time spent by the home health aide.

F15. Other (Specify under Orders) - Include other home health aide services in accordance with determination made by a registered professional nurse. Specify in item 12 HCFA-485.

234.10 HCFA-487 - The Plan of Treatment/Medical Update and Patient Information Addendum.--The addendum to the HCFA-485/486 may be used by home health agencies when additional space is required to document physician's orders from the plan of treatment or to provide additional documentation for the medical information form. If the addendum is used to document items on the plan of treatment then the form must be forwarded to the physician along with the plan of treatment. The physician's signature is not required on the addendum.

To provide additional documentation of items on the plan of treatment or medical information form, the agency should identify the item being addressed. For example, specify item number (13) on the left margin of the column. Upon completion of item 13 note the next item number, e.g., item 14, then complete that item.

1. Patient's Name

Enter the patient's last name and first name.

2. Patient's HIC Number

Enter the patient's health insurance claim number (HIC), numeric plus alpha designator.

3. Provider Number

Enter the 6 digit Medicare provider number.

4. Period Covered

Enter the from and through dates (month, day, year) which identifies the period covered by this information.

234.11 HCFA-488 - Intermediary Medical Information Request.--The intermediary will use only the HCFA-488 when necessary to obtain additional medical information in order to determine payment of home health claims. All requests to home health agencies for subsequent medical information are limited to the items listed below. The intermediary will complete items 1 through 8 for each request for additional medical information checking the item(s) they are requesting you to complete. You should provide the requested information as timely as possible. You may use the HCFA-488 to respond to items 11, 12, 13, 16, 17, and 19 as space allows. Return the HCFA-488 as a cover sheet for identification of requested information.

1. Initial Request Date - The date on which the request is initiated to the provider.

2. Final Request Date - The date that a second and final request is sent to the provider because the records were not received. This date should not exceed 30 days after the date in item number 1.

3. Provider Number - The six digit provider number.

4. Document Control Number - The number used to identify individual claims. This number is an internal processing number determined by the intermediary.

5. Patient Name - The last name, first name, middle name.

6. HI Claim Number - The patient's Medicare number including alpha designator.

7. Medical Record Number - The medical record number assigned by the provider and located in item number 3 on the HCFA-485.

8. Period of Claim - The 6 digit month, day, year dates from item 22 on the 1450 claim form. Include "From" and "Through" dates.

When pertinent to a coverage decision on a case-by-case basis, the intermediary will request one or more of the following:

9. HCFA-485/486 - Period Covered - This item will be used to request a copy of the applicable POT/MIF forms (HCFA-485/486) on interim claims where the agency was not required to submit these forms with the claim. The intermediary will enter the month, day, year dates (i.e., 60 day period) that incorporates the date of the claim. The agency should forward the applicable HCFA-485 and an updated HCFA-486 with items 1-7, 11-13, 15 and 22 completed.

10. HCFA-486 - Period Covered - This item will be checked to request only an updated HCFA-486 by entering the dates of the claim; month, day and year. The agency need complete only items 1-7, 11-13, 15 and 22.

11. Frequency of doctor's visits - This item will be checked if information is needed regarding the frequency that the patient is seen by the physician.

12. Status of Chronic Condition - This item will be checked if a narrative statement is needed to explain the status of a chronic condition that is not adequately addressed on the HCFA-485/486.

13. List primary need for: SN, PT, ST, OT, MSS, HHA, other visits - If one or more of the above services is in question as to the need for the services that have been billed, the intermediary will check the appropriate box(es). The agency should submit a narrative statement listing the reason(s) the patient requires the service.

14. Laboratory tests (frequency, types, results) - This box will be checked and the intermediary will circle one or more items as needed. The agency may use this form to reply to this item as space allows.

15. Other tests (frequency, types, results) - The intermediary will check this box and write in the name of the tests they are requesting.

16. Diet - The intermediary will check this item and the box(es) that represents the requested information.

17. Date(s) on which frequency of SN or HHA increased or decreased - The intermediary will check this box and write in the service and the frequency in question.

18. Specific progress notes for: SN, PT, ST, OT, MSS, HHA other visits - The intermediary will check this item and the box(es) specifying the type of progress notes being requested.

19. Reason for continued Medicare coverage - This item will be checked if the HCFA-485/486 information raises a question for continued coverage of services under the Medicare program.

20. Doctor's orders, signed by the physician - This item will be checked where a copy of the physician's orders or specific change of orders is requested.

21. Supplemental plans of treatment, if applicable - The intermediary will use this item to request supplemental plans of treatment when necessary to make a coverage decision. This item corresponds to item number 20 on the HCFA-486.

234.12 Postpayment Review.--Intermediaries perform a postpayment review of the medical record to ascertain that the information on the HCFA-485/486 matches that in the medical record. This review is performed a minimum of one time per calendar year for every provider served and may be performed in conjunction with coverage compliance reviews.

EXHIBIT I

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB No. [illegible]

HOME HEALTH CERTIFICATION AND PLAN OF TREATMENT

1. Patient's Name and Address

2. Patient's HI Claim Number

3. Medical Record Number

4. Dates: Start of care and verbal order for SOC

5. Certification Period:
From: To:

6. Home Health Agency Name and Address

7. Principal Diagnosis: Narrative, Dates of Onset/Exacerbation, ICD-9-CM Code
☐☐☐.☐☐

8. Surgical Procedure(s) Relevant to Care: Narrative, Date, ICD-9-CM Code
☐☐☐.☐☐

9. Other Pertinent Diagnoses — Narrative, Dates of Onset/Exacerbation, ICD-9-CM Code(s)
☐☐☐.☐☐
☐☐☐.☐☐
☐☐☐.☐☐
☐☐☐.☐☐

10.

Functional Limitations

☐ Amputation
☐ Bowel/Bladder (Incontinence)
☐ Contracture
☐ Hearing
☐ Paralysis
☐ Endurance
☐ Ambulation
☐ Mental
☐ Speech
☐ Vision
☐ Respiratory
☐ Other (Specify)

Activities Permitted

☐ Bedrest
  ☐ Complete
  ☐ BRP
☐ Up as tolerated
☐ Transfer Bed/Chair
☐ Exercises Prescribed
☐ Partial Weight Bearing
☐ Independent at Home
☐ Crutches
☐ Cane
☐ Wheelchair
☐ Walker
☐ No Restrictions
☐ Other (Specify)

11. Safety Measures:

12. Orders for Services and Treatments (Specify modality, amt/freq/dura)

13. Medications: Dose/Frequency/Route (N) New (C) Changed

14. Mental Status: ☐ Oriented ☐ Comatose ☐ Forgetful ☐ Depressed ☐ Disoriented ☐ Lethargic ☐ Agitated ☐ Other

15. Nutritional Requirements:

16. Medical Supplies & DME Ordered

17. Allergies

18. Goals/Rehabilitation Potential/Discharge Plans

19. Significant Clinical Findings/Summary from each discipline

20. Prognosis: ☐ Poor ☐ Guarded ☐ Fair ☐ Good ☐ Excellent

21. Attending Physician's Name and Address

22. PHYSICIAN CERTIFICATION:

I ☐ certify ☐ recertify that the above home health services are required and are authorized by me with a written plan for treatment which will be periodically reviewed by me. This patient is under my care, is confined to his home, and is in need of intermittent skilled nursing care and/or physical or speech therapy or has been furnished home health services based on such a need and no longer has a need for such care or therapy, but continues to need occupational therapy.

23. Attending Physician's Signature and Date

Form HCFA-485(C4) (4-88)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

EXHIBIT II

FORM APPROVED
OMB No. 0938-0357

MEDICAL UPDATE AND PATIENT INFORMATION

1. Patient's Name

2. HIC No.

3. Sex ☐ M ☐ F

4. Date of Birth

5. Medicare Covered? ☐ Yes ☐ No

6. Period Covered or Certification Period From: Through:

7. Provider Name and Number

8. Place of Treatment, If Other than Home (Name and Address)

9. Are services related to any accident or employment related injury? ☐ Yes ☐ No

10. Date and Reason Agency Last Contacted Physician

11. Is the patient receiving additional medically reasonable and necessary skilled care pursuant to a Physician's Plan of Treatment paid for by other than Medicare? ☐ Yes (Specify) ☐ No

12. Dates of Last Inpatient Stay From: To:

Type of Facility

13. Date Physician Last Saw Patient

14. SPECIFIC SERVICES AND TREATMENTS (CODES ON REVERSE)

TOTAL VISITS	SERVICES	SPECIFIC TREATMENT ORDERS	FREQUENCY AND DURATION	TX CODE

15. Updated Information: New Orders/Treatments/Clinical Facts

16. Functional Limitations/Rehabilition Potential/Goals (Each Discipline)

17. HOMEBOUND

A. Reason Homebound - Narrative:

B. Indicate any times when Home Health Agency made a visit and the patient was not home and reason why if ascertainable

C. Specify any known medical and/or non-medical reasons the patient regularly leaves home and frequency of occurrence

18. Is there an available, able and willing care giver? ☐ Yes (Specify) ☐ No

19. Unusual Home/Social Environment

20. Does your Agency have any supplementary plans of treatment on file from a physician other than the referring physician or from other specialists for care being given the patient by your agency? ☐ Yes ☐ No If Yes, Please explain briefly.

21. Other DME Available for Use

22. Signature of Nurse or Therapist Completing or Reviewing Form

Date

EXHIBIT II (Cont.)

TREATMENT CODES FOR PROFESSIONAL SERVICES REQUIRED

Skilled Nursing

A1	Skilled Observation (inc. V.S., Response to Med., etc.)
A2	Foley Insertion
A3	Bladder Instillation
A4	Wound Care/Dressing
A5	Decubitus Care
A6	Venipuncture
A7	Restorative Nursing
A8	Post Cataract Care
A9	Bowel/Bladder Training
A10	Chest Physio (inc. Postural drainage)
A11	Adm. of Vitamin B/12
A12	Prep/Adm. Insulin
A13	Adm. Other IM/Subq.
A14	Adm. IV's/Clysis
A15	Teach. Ostomy or Ileo conduit care
A16	Teach. Nasogastric Feeding
A17	Reinsertion Nasogastric Feeding Tube
A18	Teach. Gastrostomy Feeding
A19	Teach Parenteral Nutrition
A20	Teach. Care of Trach
A21	Adm. Care of Trach
A22	Teach. Inhalation Rx
A23	Adm. Inhalation Rx
A24	Teach. Adm. of Injection
A25	Teach. Diabetic Care
A26	Disimpaction/F.U. Enema
A27	Other (Spec. under Orders)

Physical Therapy

B1	Evaluation
B2	Therapeutic Exercise
B3	Transfer Training
B4	Estab. Maintenance Prog.
B5	Gait Training
B6	Chest Physiotherapy
B7	Ultra Sound
B8	Proprioceptive Neuromuscular Facilitation
B9	Passive Exercises
B10	Active Exercises
B11	Resistive Exercises
B12	Stretching Exercises
B13	Prosthetic Training
B14	Whirlpool
B15	Other (Spec. Under Orders)

Speech Therapy

C1	Evaluation
C2	Alaryngeal Speech
C3	Lang. Processing
C4	Speech/Voice
C5	Comprehensive
C6	Aural Rehab.
C7	Other (Spec. under Orders)

Occupational Therapy

D1	Evaluation
D2	ADL Training
D3	Muscle Re-education
D4	Other (Spec. under Orders)

Medical Social Services

E1	Assessment of Social and Emotional Factors
E2	Counseling
E3	Financial Assistance
E4	Placement Assistance
E5	Arrange for Meals
E6	Other (Spec. under Orders)

Home Health Aide

F1	Tub/Shower Bath
F2	Partial Bed Bath
F3	Complete Bed Bath
F4	Shave
F5	Comb Hair
F6	Catheter Care
F7	Change Linen
F8	Assist with Ambulation
F9	Transfer Bed/Chair
F10	Exercises
F11	Prepare Meal
F12	Grocery Shop
F13	Wash Clothes
F14	Housekeeping
F15	Other (Spec. under Orders)

EXHIBIT III

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB No. 0938-0227

PLAN OF TREATMENT/MEDICAL UPDATE AND PATIENT INFORMATION ADDENDUM

1. Patient's Name	2. Patient's HI Claim Number
3. Provider Number	4. Period Covered From: To:

CERTIFICATION/PLAN OF TREATMENT (CONTINUED)	MEDICAL UPDATE/PATIENT INFORMATION (CONTINUED)

Form HCFA-487(C4) (4-85)

EXHIBIT IV

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0357

HOME HEALTH AGENCY
INTERMEDIARY MEDICAL INFORMATION REQUEST

1. Initial Request Date:	2. Final Request Date:
3. Provider Number:	4. Document Control Number:
5. Patient Name:	6. HI Claim Number
7. Medical Record Number:	8. Period of Claim: From: To:
☐ 9. HCFA-485/486: Period Covered:	☐ 10. HCFA-486: Period Covered:

☐ 11. Frequency of doctors visits:

☐ 12. Status of chronic condition:

☐ 13. List primary need for:
☐ SN ☐ PT ☐ ST ☐ OT ☐ MSS ☐ HHA ☐ Other Visits

☐ 14. Laboratory tests (frequency, types, results):

☐ 15. Other tests (frequency, types, results):

☐ 16. Diet ☐ Type ☐ Compliance ☐ Teaching Duration ☐ Length of time on the diet

☐ 17. Date(s) on which frequency of SN or HHA increased or decreased:

☐ 18. Specific progress notes for:
☐ SN ☐ PT ☐ ST ☐ OT ☐ MSS ☐ HHA ☐ Other Visits

☐ 19. Reason for continued Medicare coverage:

☐ 20. Doctor's orders, signed by physician

☐ 21. Supplemental Plans of Treatment, if applicable:

Form HCFA-488(U2) (4-85)

U.S. GOVERNMENT PRINTING OFFICE - 1985 - 461-292/20396

235. TIME LIMITS FOR REQUESTS AND CLAIMS FOR PAYMENT FOR SERVICES REIMBURSED ON A REASONABLE COST BASIS

Program payment of reasonable costs may not be made under Part A or Part B for provider services unless the beneficiary or his representative has filed a timely request for payment, and the provider has filed a timely claim. (See § 233.) The intermediary has the responsibility for determining whether a claim is timely filed.

235.1 Usual Time Limit.--Effective with claims filed after December 31, 1974, the beneficiary request and the provider claim must be filed on or before December 31 of the calendar year following the year in which the services were furnished except as provided in §§ 235.2 and 235.3 below. Services furnished in the last quarter of the year are considered furnished in the following year; i.e., the time limit is 2 years after the year in which such services were furnished.

EXAMPLE 1: A Medicare beneficiary received home health services in September 1974. The beneficiary signed a request for Medicare payment at the time care started. The agency immediately submitted a start of care notice and received a prompt reply. The provider billing for the services must be filed with the intermediary on or before December 31, 1975, the close of the year following the year in which the services were furnished.

EXAMPLE 2: A Medicare beneficiary received home health services from the M Home Health Agency in November 1974 but did not inform the agency of his entitlement to Medicare at that time. His request for Medicare payment must be filed with the agency and the agency billing must be filed with the intermediary by December 31, 1976, the close of the year following the year the services were furnished.

235.2 Extension of Time Limit Due to Delay in Transmitting Reply to Start of Care Notice.--For purposes of the time limit in § 235.1 an agency shall be deemed to have filed a claim for payment for home health services on the date it submitted a start of care notice for such services, provided the claim is submitted within 60 days after the intermediary or Social Security Administration, as appropriate, replied to the start of care notice. Where the provider is establishing timely filing of the claim on this basis (i.e., the claim would not otherwise be timely filed), it should so note on the billing or an attachement to the billing and indicate the date the start of care notice was sent and the date the reply was received.

235.3 Extension of Time Limit Where Late Filing Is Due to Administrative Error.--Where SSA error (i.e., misrepresentation, delay, mistake, or other action of SSA or its intermediaries or carriers) causes the failure of the agency to file a claim for payment within the time limit in § 235.1, the time limit will be extended through the last day of the sixth calendar month following the month in which the error is rectified by notification to the provider or beneficiary, but not beyond December 31 of the third calendar year after the year in which the services were furnished. (For services furnished during October - December of a year, the time limit may be extended no later than the end of the fourth year after that year.)

The administrative error which prevents timely filing of the claim may affect the agency directly (or indirectly, i.e., by preventing the beneficiary or his representative from filing a timely request for payment). Situations in which failure to file within the usual time limit in § 235.1 will be considered to have been caused by administrative error include but are not limited to the following:

1. The failure resulted because the individual's entitlement to HI or SMI was not established until long after the month for which it was effective (e.g., a beneficiary is awarded 2 years of retroactive coverage).

2. The failure resulted from SSA's failure to notify the individual that his entitlement to HI or SMI had been approved, or in giving him (or his representative or the agency) cause to believe that he was not entitled to HI or SMI.

3. The failure resulted from misinformation from SSA or the intermediary or carrier, e.g., that certain services were not covered under HI or SMI, although in fact they were covered.

4. The failure resulted from excessive delay by SSA, the intermediary, or the carrier in furnishing information necessary for the filing of the claim (see § 235.2 concerning delay in replying to the provider's start of care notice).

5. The failure resulted from advice by SSA or an authorized agent for SSA that precluded the filing of a claim until the HHA receives certain information from the intermediary (e.g., an HHA following manual instructions does not file a billing for services where the services are expected to be paid for by workmen's compensation; but the agency learns after the expiration of the time limit of the ultimate denial of workmen's compensation liability).

The intermediary will submit to SSA for advice any claim in which delay in establishing HI or SMI entitlement or notifying an individual of HI or SMI entitlement prevents the filing of a claim until more than 3 years after the year in which the services were furnished (4 years after the year, in the case of services furnished in the last quarter of the year).

EXAMPLE 1: Information submitted in connection with a claim for services during the period May 1974 - September 1974, filed in March 1976, shows that the beneficiary's application for HI was initially denied. He was first notified on January 15, 1976, that he had HI effective May 1974. Under these circumstances, the intermediary may pay appropriate HI benefits for the services. Although the usual time limit expired December 31, 1975, the error in this case—delay in establishing HI entitlement—was not corrected until January 15, 1976, thus extending the time limit to July 31, 1976.

EXAMPLE 2: An individual requested enrollment in SMI in March 1975, the month before he attained age 65. He received covered services in July 1975, but did not request payment because he had received no notice of his SMI entitlement. Such notice was mailed to him on October 3, 1976. Although the regular time limit for the services in July 1975 expired on December 31, 1976, the claim will be considered promptly and timely filed if it is filed on or before April 30, 1977 (within the 6-month period following the month in which the notice was sent).

236. EFFECT ON BENEFICIARY AND HOME HEALTH AGENCY OF LATE FILING OR BENEFICIARY'S REFUSAL TO FILE

A. HHA Is Responsible for Not Filing Timely.—Where the beneficiary request was filed timely (or would have been filed timely had the agency taken action to obtain a request from the patient whom the provider knew or had reason to believe might be a beneficiary) but the provider is responsible for not filing a timely claim, the provider may not charge the beneficiary for the services except for such deductible and/or coinsurance amounts as would have been appropriate if Medicare payment had been made. The beneficiary's utilization is charged with the home health visits.

B. Patient Refuses to Request Medicare Payment or HHA Is Unaware of His Eligibility.—The provider may charge the beneficiary for covered services where no timely request for payment is filed by or on behalf of the beneficiary because:

1. the beneficiary refused to file. (The deductible is credited to his SSA record and visits are charged) or

2. the patient failed to bring his entitlement or possible entitlement to the attention of the agency and the agency had no other reason to believe the patient had Medicare. If the patient later brings his entitlement to Part A or Part B (whichever is required for payment for the services) to the agency's attention after the time limit and the bill is not filed timely, any deductible will not be credited and visits will not be counted.

237. FILING CLAIM WHERE USUAL TIME LIMIT HAS EXPIRED

Where it comes to the attention of a provider that health services which are or may be covered were furnished to a beneficiary but that the usual time limit in § 235.1 on filing a claim for such services has expired, the provider should take the following action:

237.1 Part A and Part B Home Health Services.--Where the provider accepts responsibility for late filing, it should file a bill with the legend "late filed claim-provider fault" (see § 430). Where the provider believes the beneficiary is responsible for late filing, it should also file a bill with the legend "beneficiary fault" and attach a statement explaining the circumstances which led to the late filing and giving the reasons for believing that the beneficiary (or other person acting for him) is responsible for the late filing and, if practicable, attach the statement of the beneficiary as to his view of these circumstances.

Where the HHA believes SSA or its agents are responsible for the late filing, it should file a regular payment bill and attach a statement explaining its view of the circumstances which led to the late filing and, if practicable, the written explanation of the beneficiary as to such circumstances.

237.2 Part B Services Other Than Home Health Services (SSA-1483 Billing).--Where the provider accepts the responsibility for the late filing, it should submit an SSA-1483 which contains the legend "late filed claim-provider fault" in the remarks section to differentiate it from a regular SSA-1483.

Where the HHA believes the beneficiary is responsible for late filing, it should file a bill, attach a statement explaining the circumstances which led to late filing and setting forth reasons for its belief that the beneficiary (or person acting for him) is responsible for the late filing and, if practicable, attach the statement of the beneficiary as to his view of the circumstances. Where the provider believes SSA or its agent is responsible for the late filing, it should proceed as in § 237.1.

237.3. Appeals.--Where the beneficiary does not agree with the determination that the claim was not filed timely or with the assignment to him of the responsibility for the late filing, the usual appeal rights are available to him, i.e., reconsideration, hearing (if the amount in controversy equals $100 or more), etc. (See § 257.) Where the provider is protesting the denial of payment or the assignment of responsibility, no formal channels of appeal are available. However, the intermediary may, at the request of the provider, informally review its initial determination.

Time Limits--Part B Charge Claims

239. TIME LIMIT FOR FILING PART B REASONABLE CHARGE CLAIMS

For Medicare payment to be made for a claim for physician and other Part B services reimbursable on a reasonable charge basis the claim must be filed no later than the end of the calendar year following the year in which service was furnished, except for services furnished in the last 3 months of a year, where the time limit is December 31 of the second year following the year in which the services were rendered. This time limit was effective with claims filed after March 1968. (See §§ 233.1 and 233.2 for effect of Federal nonworkdays and rules applicable to claims received in the mail.)

239.1 Extension of Time Limit Due to Administrative Error.--Where administrative error (that is, misrepresentation, delay, mistake, or other action of SSA or its intermediaries or carriers) causes the failure of the beneficiary or the provider, physician, or supplier to file a claim for payment within the time limit specified in § 239, the time limit will be extended through the close of the sixth calendar month following the month in which the error is rectified.

Consideration of possible extension of the time limit on Part B reasonable charge claims will be initiated by the carrier only if there is a basis for belief that the claimant (the enrollee or his representative or assignee) has been prevented from timely filing by an administrative error; for example, he states that official misinformation caused the late filing, or the social security office calls to the intermediary's attention a situation in which such error has caused late filing. (See § 235.3 for examples of administrative error.)

239.2 Time Limit Where Provider Has Billed Improperly for Professional Component.--In some cases, a provider may have incorrectly billed for a Part B professional component as a provider expense. For example, a physician's services were erroneously considered entirely administrative in nature and the error was not discovered until the final cost settlement. Where the claim which included the physician services was filed within the time limit, it establishes protective filing for a subsequent perfection of a Part B claim. Such claims will be considered filed as of the date the incorrect billing was submitted to the intermediary provided the usual claims information (e.g., a completed SSA-1554) is submitted within 6 months after the month in which the notice was sent that payment for the patient care services was disallowed.

The perfected claim may be filed by the physician on the basis of assignment, or by the HHA (where the HHA has a contractual arrangement to bill and receive payment for the physician's services) or may be filed by the patient on the basis of an itemized bill.

An agency claim filed within the Part B time limit will not establish a filing date for the related professional component where such component was recognized and not included in the provider bill, e.g., no claim was filed for the professional component as a nonprovider expense because the physician and provider could not agree on the exact amount of the component charge or who would bill for it.

239.3 Responsibility When Claim Not Filed Timely.—Where the time limit has expired on services reimbursable on a reasonable charge basis, there is no requirement that a billing be filed. However, where a person (or organization) accepts assignment within the time limit but fails to submit a timely claim, he is barred by the terms of the assignment from collecting from the patient or others amounts in excess of the deductible and coinsurance for the services involved.

Certification and Recertification

240. CERTIFICATION AND RECERTIFICATION BY PHYSICIANS—HOME HEALTH SERVICES

240.1 Content of the Physician's Certification.—Under both the hospital insurance and the supplementary medical insurance programs, no payment can be made for covered home health services unless a physician certifies that:

A. The home health services are or were required because the individual is or was confined to his home (except when receiving outpatient services);

B. The individual needed skilled nursing care on an intermittent basis or needed physical or speech therapy, or, effective July 1, 1981, needed occupational therapy;

C. A plan for furnishing such services to the individual has been established and is periodically reviewed by a physician; and

D. The services are or were furnished while the individual was under the care of a physician.

In addition, for services received under hospital insurance, the physician must certify that services were needed to treat any of the conditions for which the beneficiary received inpatient hospital or posthospital extended care services during the related hospital or skilled nursing facility stay. Effective July 1, 1981, the prior inpatient stay requirement for home health services under hospital insurance is eliminated. Where services are provided under supplementary medical insurance, it is not necessary to relate the need for these services to a period of prior hospitalization or a stay in a skilled nursing facility.

Since the certification is closely associated with the plan of treatment, the same physician who establishes the plan must also certify to the necessity for home health services. Certifications must be obtained at the time the plan of treatment is established or as soon thereafter as possible.

240.2 Method and Disposition of Certifications.—There is no requirement that the certification or recertification discussed below be entered on any specific form or handled in any specific way, as long as the intermediary can determine, where necessary, that the certification and recertification requirements are met. The certification by the physician will be retained by the home health agency, but the agency must certify on the billing form that the requisite certification and recertifications have been made by the physician and are on file in the agency when it forwards the request for reimbursement to the intermediary.

240.3 Recertification.—Under both the hospital insurance and supplementary medical insurance programs, when services are continued for a period of time, the physician must recertify at intervals of at least once every 2 months that there is a continuing need for services and should estimate how long services will be needed. The recertification should be obtained at the time the plan of treatment is reviewed since the interval (at least once every 2 months) is required for the review of the plan. Recertifications must be signed by the physician who reviews the plan of treatment. The form of the recertification and the manner of obtaining timely recertification is up to the individual agency.

240.4 Delayed Certification.—The home health agency should obtain certifications and recertifications as promptly as possible. Payment will not be made unless the necessary certifications have been secured. In addition to complying with the usual content requirements, delayed certifications and recertifications must include an explanation for the delay and any other evidence the agency considers necessary in the case. The format of delayed certifications and recertifications and the method by which they are obtained, will be left to the agency.

Special Provisions Relating to Payments

245. REFUNDS

In its agreement for participation, the home health agency has agreed not to charge any individual or other person (e.g., relatives, other insurance carriers, or welfare) for items and services covered by the health insurance program other than allowable charges and deductibles and coinsurance amounts; and to make provision for the refund (or other required disposition) of any moneys incorrectly collected from the individual or other person on his behalf. Amounts incorrectly collected and not refunded represent improper charges for covered services under the provisions of section 1866(a)(1) of the Social Security Act, and an agency's retention of these moneys without making provision for refund (or other required disposition) constitutes a violation of its provider agreement.

A. Moneys incorrectly collected means amounts in excess of allowable charges and deductible and coinsurance, if applicable, paid to a home health agency by an individual (or other person on his behalf) as payment for covered items and services for which the individual is entitled to have payment made under the health insurance program.

B. A majority of incorrect collections are made inadvertently and may involve a simple error on the part of the agency in billing a beneficiary. However, there are other situations where incorrect collection may be made; for example:

1. In a retroactive entitlement case (§ 175), where the beneficiary (or other person) paid for covered services and later becomes entitled to have payment for them under Medicare;

2. Where an intermediary has initially denied payment and a subsequent finding is made (e.g., as the result of a reconsideration or hearing decision) that payment for all or part of the same services may be made; and

3. Where the beneficiary or other person has protested a direct charge by an agency and the intermediary determines that the beneficiary is entitled to have program payment made on his behalf for all or part of the same services. (See § 257.)

Intermediaries will assure that agencies refund moneys incorrectly collected. Therefore, in the situations described above (and other similar situations recognized by the intermediary), the intermediary will ascertain, on an individual case basis, whether the agency has already received reimbursement for covered services from the individual or other person (e.g., relatives, other insurance carriers, or welfare) before making program payment. If the agency advises, in writing, that it has not been reimbursed by the individual or other person for covered services, payment can be made.

If the agency has already been reimbursed in whole or in part, the intermediary will withhold an amount equal to the incorrect collection from amounts otherwise due the agency until it is assured in writing by the agency that a proper disposition of the incorrect collection has been made.

Where the intermediary knows that a provider has overcollected deductible and coinsurance amounts (if applicable) for Part B services, the intermediary will make direct refund to the beneficiary.

245.1 Return or Other Disposition of Moneys Incorrectly Collected.-- A home health agency in possession of any incorrect collection is required to refund or make final disposition of the money in accordance with applicable State law. If refund or final disposition will be delayed for a prolonged period, the provider is required to set aside the money in a separate account until refund or final disposition can be made. Until the agency advises, in writing, that it has properly refunded or disposed of the money or, as necessary, set aside the money, the intermediary will withhold an amount equal to such incorrect collection against amounts otherwise due the HHA.

A. Refund.-- Refund is to be made to the beneficiary (or any other person) from whom the agency collected the moneys. If the beneficiary or other person cannot be located after the agency has made a reasonable effort, including an attempt to contact by mail at the last known address, the intermediary will be asked to check SSA's record in an effort to learn the individual's address. If the individual to whom refund is to be made still cannot be located or has died, the agency is to make final disposition of the moneys in accordance with the law of the State in which the agency is situated.

B. Moneys Set Aside.-- In some situations refund or final disposition may be delayed for a prolonged period (e.g., where the beneficiary's whereabouts is being developed or where there is a delay in the appointment of a legal representative to dispose of the estate of a deceased individual). When such a delay in making refund or final disposition is encountered, the provider of services will so notify the intermediary and will then set the funds aside in a separate account identified by the name of the individual to whom the payment is due. These amounts will be carried on the agency's records in this manner until refund or final disposition, as provided in paragraph A above, can be made.

245.2 Appropriate Time Limits Within Which the Home Health Agency Must Dispose of Sums Incorrectly Collected.-- Refund or final disposition in accordance with applicable State law of sums incorrectly collected should be accomplished as promptly as possible. In any event, refund, final disposition, or as necessary, setting funds aside in a separate account should be accomplished within a period of 60 days after the agency is notified that an incorrect collection was made.

245.3 Former Participating Home Health Agencies.-- Once a home health agency has become a participating agency, it remains responsible, notwithstanding the subsequent termination of its program participation, for the required refund or final disposition of any moneys incorrectly collected for covered services furnished to Medicare beneficiaries during the effective period of its provider agreement.

Automobile Medical and No Fault Insurance

248 SERVICES REIMBURSABLE UNDER AUTOMOBILE MEDICAL OR NO FAULT INSURANCE

Payment may not be made under Medicare for otherwise covered items or services to the extent that payment has been made, or can reasonably be expected to be made, for the items or services, under automobile medical or no fault insurance (including a self-insured plan). Medicare is secondary to automobile medical or no fault insurance even if State law or a private contract of insurance stipulates that Medicare is primary. If Medicare payments have been made but should not have been because they are excluded under this provision, or if the payments were made on a conditional basis in accordance with §248.2B, they are subject to recovery.

If services are covered under automobile medical or no fault insurance, the automobile insurer must be billed first. If the automobile insurer does not pay all of the charges, a claim for secondary Medicare benefits can be submitted in accordance with §248.3C to supplement the amount paid by the automobile insurer. Medicare can pay for services related to an automobile accident, if benefits are not currently available under the individual's automobile medical or no fault insurance coverage because that insurance has paid maximum benefits for the accident on items or services not covered by Medicare or on nonmedical items such as lost wages.

The question to be asked in each case involving automobile related medical expenses is whether automobile medical or no fault benefits can be paid for these particular services. If so, the automobile insurance is primary. If not, Medicare may be primary. Primary Medicare benefits cannot be paid merely because the beneficiary wants to save his/her automobile insurance benefits to pay for future services. Since automobile insurance benefits would be currently available in that situation, they must be used before Medicare can be billed.

In accordance with a "grace period" granted in the regulations, there will be no attempt to recover Medicare payments if an automobile insurance payment was received by the beneficiary before June 6, 1983. The "grace period" does not apply to insurance payments to providers of services. However, no effort will be made to recover if you turned the insurance payment over to the beneficiary before that date.

If there is an indication that the individual has filed, or intends to file, a liability claim against a party that allegedly caused an injury, follow instructions in §248.2B.

A. Effective Dates.--The general rule is that these provisions are effective with respect to services related to injuries which occurred on or after December 5, 1980. If benefits might be payable under automobile medical or no fault insurance but, for whatever reason, such benefits have not been paid, the provisions are effective with respect to services furnished on or after June 6, 1983.

Thus, for example, where an automobile insurer refuses to pay primary benefits for services furnished before June 6, 1983, because a State law or private contract of insurance stipulated that Medicare is primary, Medicare primary benefits may be paid. In the case of services furnished on or after June 6, 1983, Medicare pays only secondary benefits notwithstanding such a provision in the State law or private contract.

The specific application of the general rule follows:

1. Automobile Payment Made

a. Denial of Medicare payment; or

b. Recovery of Medicare payment, but not if the beneficiary received the automobile payment before June 6, 1983.

2. Automobile Payment Not Made -- Automobile Medical or No Fault Insurance Coverage Exists

a. Medicare primary payment for services furnished before June 6, 1983.

b. Denial or recovery of Medicare primary payment for services furnished on or after June 6, 1983. (Conditional primary Medicare payments permissible if automobile insurer contests liability.)

B. Effect on Deductibles.--Expenses for services for which Medicare payment may not be made because payment has been made or can reasonably be expected to be made under automobile medical or no fault insurance are not counted toward the Part B deductible amount.

248.1 Definitions.--

A. Automobile.--Any self-propelled land vehicle of a type that must be registered and licensed in the State where it is owned.

B. Automobile Medical or No Fault Insurance.—Insurance coverage (including a self-insured plan) that pays for all or part of the medical expenses for injuries sustained in the use of, or occupancy of, an automobile, regardless of who may have been responsible for causing the accident. (This insurance is sometimes called "personal injury protection," "medical payments coverage" or "medical expense coverage.")

C. Liability Insurance.—Insurance (including a self-insured plan) that provides payment based on legal liability for injuries or illness or damages to property. It includes, but is not limited to, automobile liability insurance, uninsured motorist insurance, homeowners liability insurance, malpractice insurance, product liability insurance, and general casualty insurance. This exclusion does not apply where the homeowner receives payment under his or her own homeowners insurance policy since such a payment does not constitute a liability insurance payment.

D. Self-Insured Plan.—A plan under which an entity (or an individual) is authorized by State law to carry its own risk instead of insuring itself with a carrier.

E. Uninsured Motorist Insurance.—Liability insurance under which the policyholder's insurer will pay for damages caused by a motorist who has no automobile liability insurance or who carries less than the amount of insurance required by law or is underinsured.

248.2 Provider Actions.—

A. Information Obtained from Patient or Representative At Start of Care.—In accordance with §341, ask Medicare patients, or the patient's representative, at the start of care if the services are for the treatment of an injury or illness which resulted from an automobile or other accident or for which they hold another party responsible. For automobile accidents, obtain the name, address and policy number of any automobile medical, no fault or liability insurance company which may be responsible for payment of medical expenses that resulted from the accident.

B. Billing Where Services Are Related to an Automobile Accident.—In the following circumstances, complete the billing form in accordance with the instructions in §495:

1. If you learn that an automobile medical or no fault insurance company may pay for otherwise covered services, bill the automobile insurance company as primary insurer. You may bill Medicare for secondary benefits per §248.3C if the automobile insurer does not pay in full for the services.

2. If the services are related to an automobile accident and an automobile insurer has been billed but does not make payment because, for example, the individual's automobile coverage expired, or the automobile medical or no fault claim is contested by the insurer, or for any other reason there will be substantial delay in resolving the claim, bill Medicare. Unless you submit a satisfactory explanation that full or partial payment cannot be made under an automobile insurance policy, the Medicare claim will be returned and you will be advised to bill the automobile insurer. If you bill Medicare and later receive payment from the automobile medical or no fault insurer, refund the Medicare payment by submitting a corrected bill.

Refusal by an individual to file a claim with an automobile insurer or to cooperate in your filing such a claim is not a basis for claiming a conditional Medicare payment.

3. If the individual files a claim against a third party for injuries suffered in an automobile accident, you may bill Medicare for otherwise covered expenses to the extent that payment has not or cannot be made by an automobile or no fault insurer or has not been made by a liability insurer. For example, an individual incurs $20,000 in medical expenses due to an automobile accident. The individual receives $5,000 in no fault insurance benefits and also has a liability claim pending against the driver of the other car. Medicare will not pay benefits for the $5,000 in expenses paid for by the no fault insurer but will pay benefits based on the additional $15,000 in expenses, subject to recovery when the liability claim is paid.

C. Request From Insurance Company or Attorney.--Notify the intermediary promptly if you receive from an attorney or insurance company a request for a copy of a medical record or bill concerning a Medicare patient. Send the intermediary a copy of the request or, if it is unavailable, full details of the request including the name and Medicare number of the patient, name and address of the insurance company and/or attorney, and the date(s) of services for which you have billed or will bill Medicare. Follow the usual rules on release of information in responding to such requests.

D. You Receive Duplicate Payments.--Refund the excess Medicare payment by submitting a corrected bill, if you receive duplicate payments from an automobile insurer and from Medicare, regardless of which payment you received first and even if you refunded the insurance payment to the beneficiary or the insurer. If you received Medicare payments for both Part A and Part B services, apply the insurance payment first to Part A expenses.

E. You Learn You Should Have Billed Automobile Medical or No Fault Insurance Instead of Medicare.--If, after you received a primary Medicare payment, you learn that the items or services could be paid for under automobile medical or no fault insurance, notify your intermediary. The intermediary will seek refund of Medicare's payment from the automobile insurer and prepare an adjustment bill, if required.

248.3 Automobile Medical or No Fault Insurance Does Not Pay in Full.--

A. Insurance Pays Service Benefits.--If the amount of payment for particular services under automobile medical or no fault insurance is less than your charges but is deemed payment in full under State law, Medicare benefits are not payable. The insurance payment constitutes a service benefit; i.e., the payment constitutes full discharge of the patient's liability to the provider.

B. Other Situations.--In other cases, automobile medical or no fault insurance may not pay your charges because the beneficiary's total medical expenses exceed the dollar limit of the coverage, or because of some other coverage limit, deductible or coinsurance applicable to all policyholders. (See §248.4.)

You are not permitted to charge a beneficiary or any other party for Medicare covered services, if you have been paid by an automobile insurer an amount that equals or exceeds the gross amount payable by Medicare, as defined in paragraph C below. This prohibition is based on the terms of your Medicare participation agreement, under which you may bill a Medicare beneficiary only for deductible and coinsurance amounts and for noncovered services.

C. Secondary Medicare Payments.—If an automobile insurer pays for Medicare covered services an amount which is less than your charges and the gross amount payable by Medicare (without considering the effect of the Medicare deductible or coinsurance or the payment by the automobile insurer), and you are not obligated to accept the insurance payment as payment in full, Medicare secondary payments can be made. In general, the Medicare secondary payment will be the gross amount payable by Medicare minus the amount paid by the automobile insurer for Medicare covered services, minus any applicable deductible or coinsurance amount. The gross amount payable by Medicare is the current Medicare interim reimbursement amount, as defined in §498.

For detailed billing and reimbursement instructions, refer to §495.

248.4 Automobile Medical or No Fault Insurance Does Not Pay All Charges Because of Deductible or Coinsurance Provision in Policy.— In a number of States automobile insurers may reduce automobile medical or no fault insurance benefits by deductible or coinsurance amounts. If such contract provisions apply to all policyholders, Medicare pays benefits with respect to otherwise Medicare-covered expenses that are not reimbursable under such an automobile insurance contract. The usual Medicare deductibles and coinsurance are applied in calculating the Medicare secondary payment. Therefore, if an automobile medical or no fault insurer has been billed and has made no payment or only a partial payment (e.g., the automobile insurance deductible has been bridged) because of a deductible or coinsurance, you may bill Medicare and should complete the billing form in accordance with §495.

Example 1: Beneficiary receives outpatient hospital services covered by no fault automobile insurance. Total charges are $200. The automobile insurer is billed but makes no payment because of $1000 deductible in policy. Hospital bills Medicare for $200 in accordance with §495F.

Example 2: Beneficiary's home health care is covered by no fault automobile insurance, which allows agency's full charges but reduces payment by $800 remaining unmet in $1000 deductible provision in policy. You may bill Medicare for $800 in accordance with §495E.

Example 3: Beneficiary's home health care paid for by no fault automobile insurance except for $1000 deductible, for which you may bill Medicare in accordance with §495E.

Workers' Compensation

250. GENERAL INFORMATION

Payment under Medicare may not be made for any items and services to the extent that payment has been made or can reasonably be expected to be made for such items or services under a workers' compensation law or plan of the United States or a State. Moreover, if it is determined that any Medicare payment has been made for items and services which can be or could have been paid for under workers' compensation, the Medicare payment constitutes an overpayment.

This exclusion is applicable to the workers' compensation plans of the 50 States, the District of Columbia, Guam, and Puerto Rico. It also applies to the Federal workers' compensation plans provided under the Federal Employees' Compensation Act, the U.S. Longshoremen's and Harbor Workers' Compensation Act and its extensions, and the Federal Coal Mine Health and Safety Act of 1969 as amended (the Federal Black Lung program).

These Federal programs provide workers' compensation protection for Federal civil service employees and certain other categories of employees not covered, or not adequately covered, under State workers' compensation programs; e.g., coal miners totally disabled due to pneumoconiosis, maritime workers (with the exception of seamen), employees of companies performing overseas contracts with the United States government, employees of American companies who are injured in an armed conflict, employees paid from non-appropriated Federal funds (such as employees of post-exchanges), and offshore oil field workers.

The Federal Employers' Liability Act, which covers merchant seamen and employees of interstate railroads, is not a workers' compensation law or plan for purposes of this exclusion. Similarly, some States have employers' liability acts. These also are not considered workers' compensation acts for purposes of this exclusion.

The beneficiary is responsible for taking whatever action is necessary to obtain payment under workers' compensaton where payment under that system can reasonably be expected. Failure to take proper and timely action under such circumstances precludes payment under Medicare to the extent that payment could reasonably be expected under workers' compensation had the beneficiary exercised his benefit rights under that system.

250.1 Characteristics of Workers' Compensation Programs.-- A workers' compensation program is a government-supervised and employer-supported system for compensating employees for injury or disease suffered in connection with their employement, whether or not the injury was the fault of the employer. About 80 percent of the nation's work force has workers' compensation protection. The noncovered group consists primarily of argricultural employees, interstate railroad employees, employees of small businesses (e.g., domestic employees), casual employees, and self-employed people. It should be noted that wide variations exist from State to State in coverage and other provisions of the various compensation programs.

Although workers' compensation programs were initially designed to cover accidental injuries suffered in the course of employment, all States now provide compensation for at least some occupational diseases

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as well. In most States, occupational disease coverage extends to all types of occupational diseases. However, some laws limit coverage to enumerated conditions.

All workers' compensation acts require that the employer furnish the employee with necessary medical and hospital services, medicines, transportation, apparatus, nursing care, and other necessary restorative items and services. However, in some States there are limits on the amount of medical and hospital care provided.

250.2 Effect of Payments Under a Workers' Compensation Plan.—In general, expenses for services which are compensable under a workers' compensation program are not reimbursable under Medicare.

A. Spell of Illness.—Where a beneficiary receives inpatient hospital services or extended care services, a spell of illness begins on the first day (not included in a previous spell of illness) on which he receives such services even though the services are paid for by workers' compensation.

B. Benefit Utilization.—In most instances, where an injury or illness is covered under a workers' compensation plan, that plan will pay all hospital and medical expenses. Where this is the case, services paid for under workers' compensation will not reduce the individual's future entitlement under health insurance. Thus, services paid for by workers' compensation will not be counted against the individual's entitlement to 100 home health visits under Part A or 100 home health visits under Part B. Effective July 1, 1981, the 100 Part A and 100 Part B visit limitations are eliminated.

C. Deductibles and Coinsurance.—Payments made under workers' compensation cannot be applied toward the health insurance deductible and coinsurance amounts. Thus, for example, medical expenses do not count towards the Part B deductible if paid for under workers' compensation or if such payment is reasonably expected.

250.3 Partial Payment Under Workers' Compensation.—Where workers' compensation does not pay for all services furnished a beneficiary, Medicare benefits may be paid for services not covered by the workers' compensation payment. Thus, for example, some Medicare benefits may be payable where only a portion of the services furnished a Medicare beneficiary are compensable because of a limitation on the total amount that can be paid for medical care under workers' compensation. Similarly, benefits may also be payable where a patient received services for a nonwork-related condition concurrently with services which were work-related or where an individual receives a lump-sum settlement of a workers' compensation claim. If situations such as the above arise in which it appears that only a portion of the services furnished a beneficiary may be covered under workers' compensation, the provider should send the intermediary a complete description of the circumstances of the particular case and should ask the intermediary for specific instructions as to what portion of the bill, if any, is covered by Medicare and how to bill for any covered services.

250.4 Provider Handling of Cases Involving Work-Related Conditions.—

A. General.—Information supplied by the HHA is a means of alerting intermediaries to actual or potential workers' compensation coverage in specific cases involving work-related conditions. A condition would be considered to be work-related if it resulted from (1) an accident that occurred on the job, or (2) an occupational disease. The work-related question on the start of care and billing form (section 405, Item 16) should be answered affirmatively if any of the following conditions apply:

1. The physician or the patient states that the condition is work-related;

2. The condition, or serious aggravation thereof, resulted from an accident which occurred in the course of the individual's employment, e.g., the patient fell from a scaffold while at work;

3. The diagnosis is one which is commonly associated with employment; e.g., pneumoconiosis (including silicosis, asbestosis and "black lung" disease in the case of a coal miner); radiation sickness, anthrax, undulant fever; dermatitis due to contact with industrial compounds; and lead, arsenic, or mercury poisoning;

4. The beneficiary previously received workers' compensation for the same condition;

5. There is indication that a workers' compensation claim is pending;

6. There is other indication that the condition arose on the job.

B. Responsibility of Provider to Document Cases in Which There is a Possibility of Workers' Compensation Coverage.-Providers of services are expected to inquire of the beneficiary or treating physician whether the condition is work-related. Where the patient or his physician indicates that the condition is work-related or there is other indication that the condition is work-related (e.g., where any of the conditions in 2 through 6 above exist), the provider is required to ask the patient or his physician, wherever possible, whether workers' compensation is expected to pay for the services.

1. Notice of Start of Care and Billing Where Workers' Compensation Has Paid or is Expected to Pay for Services Otherwise Covered by Medicare.-- Where workers' compensation has paid for all services or where the patient or his physician indicates that all of the services will be paid for by a workers' compensation program (whether at the provider's customary charge rate or at a special workers' compensation rate) or where the provider is authorized to bill under workers compensation, the provider need not submit a start of care notice or billing form.

If it develops subsequently that the workers' compensation claim is denied or a workers' compensation claim is not filed within 60 days of the date of the first home health service, the provider should submit (a) a start of care notice and bill in accordance with the regular billing procedure, (b) a supplementary statement calling attention to the circumstances, and (c) an authorization signed by the beneficiary or his representative permitting the intermediary to obtain additional information concerning the issue of workers' compensation from the employer, the workers' compensation carrier, or any other source.

2. Patient or Physician Denies Workers' Compensation Coverage for Work-Related Condition.-- If the patient or physician denies that workers' compensation benefits are payable for a condition which the provider believes may be covered by workers' compensation, a supplementary statement will be attached to the start of care notice or billing form containing information about the circumstances of the accident or disease and the reasons it is claimed that workers' compensation benefits are not payable. In addition, the provider will obtain and forward to the intermediary, authorization signed by the beneficiary or his representative permitting the intermediary to obtain additional information concerning the issue of workers' compensation from the employer, the workers' compensation carrier or any other source.

Automobile and Liability Insurance

251 SERVICES REIMBURSABLE UNDER AUTOMOBILE, NO FAULT OR ANY LIABILITY INSURANCE

251.1 General.—Payment may not be made under Medicare for otherwise covered items or services to the extent that payment has been made, or can reasonably be expected to be made, for the items or services under an automobile or liability insurance policy or plan (including a self-insured plan), or under no fault insurance. (If Medicare payments have been made but should not have been because the services are excluded under this provision, or if the payments were made on a conditional basis in accordance with §251.3B, they are subject to recovery.)

Regulations to implement Section 953 of the Omnibus Reconciliation Act of 1980 were published on April 5, 1983. They give effect to the position that Medicare is secondary even if a state law or a private contract of insurance stipulates that Medicare is primary. Medicare payments will not be denied if automobile medical or no fault insurance will not pay because of such a Medicare primacy clause in the automobile insurance policy. However, if cases arise in which automobile insurers continue to disallow payments on this ground for services furnished on or after June 6, 1983, the Medicare payments will be conditioned on the beneficiary refunding the Medicare payment in the event that payment is later made by the automobile insurer. (See § 251.3B and E).

A. Automobile Medical or No Fault Insurance.—If services are covered or have been paid for under automobile medical or no fault insurance, Medicare payment may not be made for otherwise covered services even if the State no fault law or private insurance contract stipulates that the automobile benefits are secondary to Medicare's. Providers should bill the automobile insurer whenever there is coverage under an automobile medical or no fault policy. If the automobile insurer contests the claim or there will be substantial delay in its decision, Medicare payment will be made subject to recoupment if the automobile insurer pays the claim.

B. Liability Insurance.—If a Medicare beneficiary has filed or plans to file a liability claim against a party that allegedly caused an injury or illness, Medicare will initially pay for services related to that injury or illness (if they are otherwise covered). Since liability claims are usually not settled or adjudicated until after protracted negotiations and possible litigation, payment by a liability insurer cannot reasonably be expected merely because a beneficiary has filed a liability claim. However, Medicare payment is conditioned on recovery from the beneficiary, if the beneficiary later receives a judgment on, or settlement of, the claim which results in payment by a liability insurer or a self-insured party.

C. Effective Dates.—The general rule is that these provisions are effective with respect to services related to injuries which occurred on or after December 5, 1980. (In the case of a liability claim based on illness rather than trauma, these provisions are effective with respect to services furnished on or after December 5, 1980, unless the liability award or settlement specifies that the illness was caused solely by an occurrence or activity that took place before December 5, 1980.) The specific application of the general rule is as follows:

1. **Automobile Medical or No Fault Insurance Coverage Exists**

a. **Automobile Payment Made**

(1) Denial of Medicare payment; or

(2) Recovery of Medicare payment, but not if the beneficiary received the automobile payment before June 6, 1983.

b. **Automobile Payment Not Made**

(1) Medicare payment for services furnished before June 6, 1983.

(2) Denial of Medicare payment for services furnished on or after June 6, 1983. (Conditional Medicare payments permissible if automobile insurer contests liability.)

2. **Liability (Including Automobile Liability) Insurance Claim Filed**

a. **Liability Payment Made**

(1) Denial of Medicare payment; or

(2) Recovery of Medicare payment for services rendered up to the date of the liability payment, but not if the beneficiary received the liability payment before June 6, 1983.

b. **Liability Payment Not Made**

(1) Conditional Medicare payment, and

(2) Recovery of Medicare payment, but not if the beneficiary receives liability payment before June 6, 1983.

D. Effect on Deductibles.—Expenses for services for which Medicare payment may not be made because payment has been made or can reasonably be expected to be made under automobile or liability insurance are not counted toward the applicable Part B deductible amounts.

251.2 Definitions.—

A. Automobile.—Any self-propelled land vehicle of a type that must be registered and licensed in the State where it is owned.

B. Automobile Medical or No Fault Insurance.—Insurance coverage (including a self-insured plan) that pays for all or part of the medical expenses for injuries sustained in the use of, or occupancy of, an automobile, regardless of who may have been responsible for causing the accident. (This insurance is sometimes called, "personal injury protection," "medical payments coverage" or "medical expense coverage.")

C. Liability Insurance.—Insurance (including a self-insured plan) that provides payment based on legal liability for injuries or illness or damages to property. It includes, but is not limited to, automobile liability insurance, uninsured motorist insurance, homeowners liability insurance, malpractice insurance, product liability insurance, and general casualty insurance. This exclusion does not apply where the homeowner receives payment under his or her own homeowners insurance policy since such a payment does not constitute a liability insurance payment.

D. Self-Insured Plan.—A plan under which an entity (or an individual) is authorized by State law to carry its own risk instead of insuring itself with a carrier.

E. Uninsured Motorist Insurance.—Insurance under which the policy holder's insurer will pay for damages caused by a motorist who has no automobile liability insurance or who carries less than the amount of insurance required by law or is underinsured.

251.3 Provider Actions.—

A. Information Obtained from Patient or Representative At Time of Start of Care, or From Hospital or SNF.—Ask Medicare patients, or the patient's representative, at the time of start of care, if the services are for treatment of an injury or illness which resulted from an automobile or other accident or for which he or she otherwise holds another party responsible. If the services are for treatment of an automobile accident, ask the beneficiary for the name and address of any automobile medical, no fault or liability insurance company which may be responsible for payment of medical expenses which resulted from the accident. Some or all of this information may be available from the hospital or skilled nursing facility where a beneficiary inpatient stay preceded HHA services.

B. Billing Where Services Are Related to an Automobile Accident.—In the following circumstances , annotate the billing form in accordance with the applicable instructions in § 494:

1. If you learn that an automobile medical or no fault insurance policy or plan (including a self-insured plan) may pay for otherwise covered services, bill the automobile insurance company as primary insurer. If an automobile insurer has been billed but did not pay the bill in full, e.g. , where the expenses are greater than the limits of the insurance policy, bill Medicare as secondary payer. (See also §251.4.)

2. If you have evidence establishing that the services are not covered under the individual's automobile medical or no fault insurance, e.g., the individual's automobile insurance coverage expired, bill Medicare. The intermediary may contact the beneficiary about possible liability coverage.

3. If an automobile medical or no fault claim is contested by the insurer, or for any other reason there will be substantial delay in resolving the claim, bill Medicare. If payment is later received from the insurer, submit an adjustment bill to refund the Medicare payment.

4. If expenses are covered under automobile medical or no fault insurance, and the individual also files a claim against a third party for injuries suffered in the same accident, bill Medicare for otherwise covered expenses not covered by the automobile medical or no fault insurance and not paid for by a liability insurer. For example, an individual incurs $20,000 in medical expenses due to an automobile accident. The individual receives $5,000 in reimbursement from an automobile insurer and also has a liability claim pending against the driver of the other car. Medicare will not pay benefits for the $5,000 in expenses paid for by the automobile insurer but will pay benefits based on the additional $15,000 in expenses, subject to recovery when the liability claim is paid.

C. Billing Where Services Are Related to an Accident Other Than an Automobile Accident.—If you learn that otherwise covered services are related to an accident that was not an automobile accident, bill Medicare to the extent that the services have not been paid for by a liability insurer and annotate the bill in accordance with § 494. The intermediary may contact the beneficiary about possible liability coverage. (If a liability insurer is willing to pay for the services, you may bill the insurer instead of Medicare.) For purposes of this instruction, "accident" means any occurrence or activity that the individual believes resulted in injury or illness for which he or she holds another party liable. See also §252.2C above, for definition of liability insurance.

D. Request From Insurance Company or Attorney.—Notify the intermediary promptly if you receive from an attorney or insurance company a request for a copy of a medical record or bill concerning a Medicare patient. Send the intermediary a copy of the request or, if it is unavailable, full details of the request including the name and Medicare number of the patient, name and address of the insurance company and/or attorney, and the date(s) of services for which you have billed or will bill Medicare. Follow the usual rules on release of information in responding to such requests.

E. Provider Receives Duplicate Payment.—Refund the Medicare payment by submitting an adjustment bill if you receive payment for the same services from the beneficiary or an automobile or liability insurer and from Medicare, regardless of which payment you received first and even if you have already refunded the automobile insurance payment to the insurer or to the beneficiary.

If you have received payment from Medicare, and the beneficiary received an automobile or liability insurance payment through you or directly from the insurer, the beneficiary is required to refund the Medicare payment up to the amount of the insurance payment, but not if he or she received the insurance payment before June 6, 1983.

251.4 Automobile or Liability Insurer Pays in Part for Visits or Services.--In some cases, automobile medical or no fault insurance will not pay an HHA's estimated cost in full because medical expenses exceed the dollar limit of the coverage or because of some other coverage limit. Although Medicare will ordinarily pay first when liability insurance is involved, it may also happen that a liability insurer will pay first and will not pay the estimated costs in full. The intermediary determines the amount of Medicare payment to the HHA in such cases. Medicare will pay the difference between the current Medicare interim reimbursement amount for visits or services under §497 (unreduced by any coinsurance or deductible, where applicable (e.g., durable medical equipment, ambulance service billed on HCFA-1483)) and the automobile or liability insurer's payment, subject to any applicable Medicare deductible or coinsurance.

Example: An individual received 7 home health visits for which the total charges were $160 and for which an automobile insurer paid $70. Medicare interim reimbursement for the same services in the absence of the insurance payment would have been $140 ($20 per visit). Medicare interim reimbursement minus the automobile insurer's payment is $70 ($140 -$70). Medicare pays that amount on an interim basis.

252 LIMITATION ON PAYMENT FOR SERVICES TO INDIVIDUALS ENTITLED TO BENEFITS SOLELY ON THE BASIS OF END STAGE RENAL DISEASE WHO ARE COVERED BY EMPLOYER GROUP HEALTH PLANS

252.1 General.—Medicare benefits are secondary to benefits payable under an employer group health plan in the case of individuals who are entitled to benefits solely on the basis of end stage renal disease (ESRD) (see §167), during a period of up to 12 months, which is defined in §§252.4 and 252.5. Medicare is secondary during the period specified in §§252.4 and 252.5 even though the employer policy or plan contains a provision stating that its benefits are secondary to Medicare's or otherwise excludes or limits its payments to Medicare beneficiaries.

Under this provision, home health agencies (HHA's) may bill either Medicare or the EGHP first. If an HHA bills Medicare first, Medicare will pay conditional primary benefits and then attempt to recover from the EGHP. If an HHA bills an EGHP first, and the EGHP does not pay for the services in full, Medicare may pay secondary benefits in accordance with §252.10.

There may be instances where there is more than one primary insurer (e.g., automobile medical insurer and EGHP). In such cases, the primary insurers will customarily coordinate benefits. Medicare is secondary to all primary insurers.

The provision is effective for items and services furnished on or after October 1, 1981 to beneficiaries whose 12-month periods began in or after October 1981. Consider the possible application of this limitation on benefits when billing for items or services furnished to ESRD beneficiaries who are in their first year of entitlement.

NOTE: The instructions in these sections do not apply to beneficiaries entitled to Medicare because of age 65 or disability.

252.2 Definitions.—

A. Employer—The term "employer" as used in these instructions means, not only individuals and organizations engaged in a trade or business, but also embraces organizations exempt from income tax, such as religious, charitable, and educational institutions as well as the governments of the United States, the States, Territories, Puerto Rico, Guam, the Virgin Islands, and the District of Columbia, including their agencies, instrumentalities and political subdivisions. For purposes of the ESRD secondary payer provision the term "employer" is defined without regard to number of employees.

B. Employer Group Health Plan or Employer Plan—These terms mean any health plan that is of, or contributed to by, an employer and that provides medical care, directly or through other methods such as insurance or reimbursement to current or former employees, or to current or former employees and their families. The Federal Employees Health Benefits program meets the definition of EGHP. Employee pay-all plans, i.e., group health plans that do not receive any contribution from the employer, also meet the definition of EGHP. However, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is not included in the definition of EGHP.

It will be assumed in the absence of evidence to the contrary, that any health plan (including a union plan) in which a beneficiary is enrolled because of the current or former employment of the beneficiary or of a member of the beneficiary's family meets this definition.

C. Secondary—For purposes of this instruction the term "secondary," when used with respect to Medicare payment, means that Medicare will be residual payer to all employer plans under which the Medicare beneficiary is covered and will either pay conditional primary benefits and later recover from the employer plan or, if the employer plan pays first, will pay only secondary benefits in accordance with §252.10 to supplement the primary payment. The workers' compensation exclusion (§251ff.) and automobile and liability insurance provisions (§250ff.) must also be taken into consideration in determining the extent of Medicare's liability as a residual payer since in some cases there may be a primary insurer in addition to the EGHP.

D. Coordination Period.--The term "coordination period" means a period of up to 12 months determined in accordance with §§252.4 and 252.5 during which Medicare benefits are secondary to benefits payable under employer group health plans.

252.3 Retroactive Application.--If the intermediary notifies you, or you learn from other sources that an employer plan may be primary payer for services for which Medicare paid primary benefits, take the following actions:

(1) ascertain whether there is employer plan coverage and if so, the name and address of the employer plan, where that information is not already annotated on the claim,

(2) check your records and ascertain whether Medicare paid primary benefits for other services for which an employer plan may be primary,

(3) notify the intermediary of the results of your development efforts on each of these claims.

This information is necessary for Medicare to determine its proper payment. If the employer plan pays or has already paid you for all or part of the services, submit a corrected bill to the intermediary in accordance with §445 along with the employer plan's explanation of benefits (EOB). The intermediary will recoup from you the amount of conditional Medicare benefits paid in excess of any amount it is obligated to pay as secondary payer.

252.4 Determining the Months During Which Medicare May Be Secondary Payer.—Medicare may be secondary payor to employer group health plans for items and services furnished during a period of up to 12 consecutive months which begins with a month after September 1981. The 12-month period begins with the earlier of:

(1) the month in which a regular course of renal dialysis is initiated or

(2) in the case of an individual who receives a kidney transplant, the first month in which the individual became entitled to Medicare.

Note: In the extremely rare case of an untimely application by an individual who receives a transplant, the 12-month period could begin with the first month in which the individual would have been entitled to Medicare benefits if he/she had filed a timely application for such benefits. (See § 167 for the earliest possible month of entitlement in transplant cases.) It is not necessary to consider this possibility absent a specific indication, e.g., information in file that the transplant occurred before the first month of entitlement. If further development is required contact the Social Security office.

When the 12-month period begins before the month the individual becomes entitled to Medicare, Medicare pays secondary benefits for the portion of the period during which the individual is entitled to Medicare benefits. This is the coordination period (see § 252.2 D). Since Medicare entitlement usually begins with the third month after the month in which the individual starts a regular course of dialysis, Medicare will usually be the secondary payer for the first 9 months of an individual's entitlement. However, for those individuals who undertake a course in self-dialysis training or who receive a kidney transplant during the 3-month waiting period, Medicare may be the secondary payer for up to the first 12 months of the individual's Medicare entitlement.

The following examples illustrate how to determine the number of months in which Medicare pays secondary benefits for various situations in which benefits are payable by an employer group health plan:

(1) Individual became entitled to Medicare after a waiting period

(a) Janice started a regular course of dialysis in October 1981. The 12-month period begins in October 1981 (the month in which Janice started a regular course of dialysis) and the waiting period consists of October, November and December 1981. Medicare is secondary payer from January through September 1982.

(b) Peter started a regular course of dialysis in January 1982 and was hospitalized and received a kidney transplant in March 1982. The 12-month period begins with January 1982. The kidney transplant cuts short the dialysis waiting period so that Peter becomes entitled in March 1982. Medicare is secondary payer from March through December 1982.

(2) Individual became entitled to Medicare without a waiting period.—In October 1982 John began a regular course of dialysis. In December 1982 John began a course of self-dialysis training. Since the self-dialysis training course was initiated during the first 3 months of dialysis, he is exempt from the waiting period and becomes entitled as of October 1982, the first month of dialysis. In this situation the first month of entitlement coincides with the beginning of the 12-month period. Thus, the coordination period extends from October 1982 through September 1983. Medicare is secondary payor during this period.

252.5 Effect of Changed Basis for Medicare Entitlement.—If the basis for an individual's entitlement to Medicare changes from ESRD to age 65 or disability, the coordination period terminates with the month before the month in which the change is effective.

252.6 Subsequent Periods of ESRD Entitlement.—If an individual has more than one period of entitlement based solely on ESRD, a coordination period will be determined for each period of entitlement in accordance with §§252.4 and 252.5.

252.7 Identification of Cases in Which Medicare May Be Secondary to Employer Group Health Plans.—Investigate cases in which information available to you (e.g., the beneficiary's Medicare card or the query reply) indicates that the beneficiary is entitled to Medicare based on end stage renal disease for 1 year or less at the time the services were rendered to ascertain whether the services were rendered during the 12-month period described in §§252.4 and 252.5. Determine whether the services were rendered in the 12-month period by checking your own records; e.g., information contained on the HCFA Form 2728 or, if the potential Medicare payment is $50 or more, with other providers or facilities, or the beneficiary's physician, if necessary, to determine the date the individual started a regular course of dialysis or the date the individual received a kidney transplant (or entered a hospital to receive a transplant). If the individual is in the 12-month period described in §§252.4 and 252.5, inquire of the beneficiary if he/she is insured under any health insurance plan which provides coverage to the beneficiary through the employer or through a union. If the response is yes, ask the beneficiary for the name and address of the plan and the beneficiary's identification number.

If the information you obtain does not indicate employer group plan coverage but the query response indicates Medicare was the secondary payer on a previous claim based on ESRD, verify the absence of EGHP coverage by inquiring of the beneficiary or the beneficiary's representative. If you verify the absence of EGHP coverage, annotate the bill to that effect (e.g., EGHP coverage lapsed, benefits exhausted). If the information you obtain indicates that EGHP coverage exists, obtain the information cited above from the beneficiary or the beneficiary's representative.

252.9 Action Where Medicare is Secondary to Employer Group Health Plan.—

A. General.—If you determine, based on your development, that Medicare may be secondary to an employer plan, you may bill either the employer plan for primary benefits, and bill Medicare, as secondary payer, or you may bill Medicare for conditional primary benefits. If Medicare pays conditional primary benefits, the intermediary later recovers the excess Medicare payment from the EGHP. (The excess Medicare payment is the difference between the Medicare conditional primary payment and the amount Medicare is obligated to pay as secondary payer.)

When the intermediary recovers all or part of a Medicare conditional primary payment from an EGHP, it will allocate the EGHP payment in the following order: first, it will refund to the HHA any deductible and coinsurance amounts that had been subtracted from the Medicare payment; second, it will recover the excess Medicare payment; and third, it will send the HHA the balance of the EGHP refund, if any. When you receive such refunds from the intermediary, either credit the beneficiary's account for any unpaid deductible and coinsurance amounts, or refund these amounts to the party that paid them.

B. Billing Medicare for Primary Benefits.—If you decide to bill Medicare for conditional primary benefits, be certain to complete the bill in accordance with §496F. The intermediary will return bills that do not contain requisite information regarding EGHP coverage. The intermediary needs this information to enable it to later recover any excess Medicare payment from the EGHP.

If you are billing Medicare for conditional primary benefits because the EGHP has denied a claim for primary benefits, annotate the bill with the EGHP's explanation of the reasons for its denial in accordance with §496A.

If you are paid conditional primary Medicare benefits and later receive payment for the same services from an employer plan, submit a corrected bill to the intermediary in accordance with §445 and include a copy of the employer plan's explanation of benefits. The intermediary will determine if secondary Medicare reimbursement would have been due the HHA if Medicare had not paid primary conditional benefits and will recoup from you the amount of conditional Medicare benefits paid in excess of any amount Medicare is obligated to pay as secondary payer.

C. Billing Medicare for Secondary Benefits.—If an employer plan payment for Medicare covered services is less than your charges and the current Medicare interim reimbursement amount (as defined in §498) payable by Medicare in the absence of employer plan payment, and you are not obligated to accept the plan payment as payment in full, secondary Medicare benefits may be payable on the claim in accordance with §252.10. Prepare the bill in accordance with §496.

252.10 Amount of Secondary Medicare Payments Where Employer Group Health Plan Pays in Part for Visits and Services.—The Medicare secondary payment will be the lower of the following:

(a) The current Medicare interim reimbursement amount (without regard to the Medicare deductible or coinsurance amounts or the payment by the EGHP) minus the amount paid by the employer plan for Medicare covered services, or

(b) The current Medicare interim reimbursement amount (without regard to the Medicare deductible or coinsurance amounts or the payment by the EGHP) minus any applicable Medicare deductible or coinsurance amount.

The current Medicare interim reimbursement amount is defined in §498. For detailed billing and reimbursement instructions, refer to §496.

252.11 Employer Group Health Plan Pays in Full.—If an employer plan payment for Medicare covered services equals or exceeds your charges or the current Medicare interim reimbursement amount payable by Medicare for the services in the absence of employer plan coverage, or if you are obligated to accept the plan payment as payment in full, no Medicare payment is due. Any excess of the employer plan payment over the current Medicare interim reimbursement amount payable by Medicare will not be subtracted from your Medicare reimbursement at final cost settlement. When appropriate, submit a no payment bill in accordance with §496.

252.13 Effect of EGHP Payments On Deductible and Coinsurance.—Expenses that would be applied to a beneficiary's Part B cash deductible if Medicare were primary payer, will be credited to the deductible if the expenses are reimbursed by an EGHP. This is true even if the EGHP paid the entire bill and there is no Medicare benefit payable. Also, EGHP payments to an HHA will be applied to satisfy a beneficiary's obligation to pay a Part B coinsurance amount. However, EGHP payments will be credited to the deductible before being used to satisfy the coinsurance. (See §496.)

252.14 Limitation on Right of Home Health Agency to Charge a Beneficiary.—A home health agency may not charge a beneficiary or any other party for Medicare covered services, if it has been paid by an employer plan at least an amount equal to any applicable Medicare deductible or coinsurance amount.

EXAMPLE: Services were furnished to a Medicare beneficiary for which covered charges were $90. No part of the beneficiary's $75 Part B deductible had been met previously. An EGHP paid $85 for the Medicare covered services. The current Medicare interim reimbursement amount (without regard to Medicare deductible and coinsurance amounts) for these services at 90 percent of charges would be $81. Medicare will make no payment since the EGHP payment was greater than Medicare's interim reimbursement amount of $81 would have been. The HHA may not charge the beneficiary for the $5 difference between the HHA's charges and the EGHP payment since the beneficiary's obligation ($78 for the Medicare deductible and coinsurance*) was met by the EGHP payment.

*The coinsurance is calculated as follows:

$90 charges minus $75 deductible = $15 X 20 percent = $3 coinsurance.
The beneficiary's obligation of $78 is met by the EGHP payment of $85.

252.15 EGHP Erroneously Pays Primary Benefits.—If you determine that an EGHP has inappropriately paid primary benefits, bill Medicare as primary payer and refund to the EGHP the amount it paid, except for an amount equivalent to Medicare deductible and coinsurance amounts, and charges for noncovered services.

Limitation on Payment for Services to Employed Beneficiaries and Their Spouses Age 65-69

253. MEDICARE SECONDARY FOR EMPLOYED INDIVIDUALS AND THEIR SPOUSES AGE 65 THROUGH 69.

253.1 General.—Medicare benefits are secondary to benefits payable under employer group health plans (EGHPs) for employees age 65 through 69 and their spouses age 65 through 69 and effective January 1, 1985, spouses age 65 through 69 of employees of any age through 69. §253.3 further defines the individuals subject to this limitation on payment. This provision is effective for items and services furnished on or after January 1, 1983. If primary Medicare benefits have been paid for services furnished on or after January 1, 1983 to an individual who meets the criteria in §253.3, the intermediary will recover the Medicare overpayment and instruct the HHA to take action in accordance with §253.14. Billing instructions are in §497.

In general, where an individual meets the criteria in §253.3, bill the EGHP first and, if (1) the plan payment is less than the HHA's charges for Medicare covered services, (2) the plan payment is less than the gross amount payable by Medicare as defined in §253.12, and (3) the HHA is not obligated to accept the EGHP payment as payment in full, Medicare secondary benefits may be payable in accordance with §253.12.

Employers (as defined below) are required to offer to their age 65-69 employees and to the age 65-69 spouses of employees of any age through age 69, primary coverage through the month before the month of their attainment of age 70. (From January 1, 1983 through July 17, 1984 employers were required to offer primary EGHP coverage through the month of attainment of age 70.) Medicare beneficiaries are free to reject the employer coverage, in which case they retain Medicare as the primary coverage. Effective January 1, 1983, employers cannot offer such employees or their spouses coverage on a supplemental basis of services covered by Medicare.

Where an EGHP pays benefits as primary payer, but does not pay in full for the services, secondary Medicare benefits may be paid as prescribed in §253.12 to supplement the amount paid by the EGHP for Medicare covered services. Medicare will be the primary payer where an individual has not accepted the primary coverage offered by the employer. If an EGHP denies payment for particular services because they are not covered by the plan, primary Medicare benefits may be paid for them if covered by Medicare.

An EGHP's decision to pay or deny a claim because it determines that the services are or are not medically necessary is not binding on the Medicare intermediary. Medicare will continue to evaluate claims under existing guidelines derived from the law and regulations to assure that services are in fact covered by the program regardless of employer plan involvement.

253.2 Definitions.--

A. Employer.--The term "employer" as used in these instructions means not only individuals and organizations engaged in a trade or business, but also embraces organizations exempt from income tax, such as religious, charitable, and educational institutions. Included are the governments of the United States, the States, the Territories, the Virgin Islands, Guam, Puerto Rico and the District of Columbia. Only employers with 20 or more employees are required to offer primary coverage to their age 65-69 employees and the age 65-69 spouses of employees. (This requirement is met if an employer has 20 or more full-time and/or part time employees for each working day in each of twenty or more calendar weeks in the current or preceding year.)

Assume for purposes of the requirement that EGHPs be billed before Medicare that, in the absence of evidence to the contrary, an employer in whose health plan a beneficiary is enrolled because of employment meets the definition of employer and employs at least 20 people. An employer allegation that the 20-employee requirement is not met or a multiemployer plan's statement identifying specific members as employees of employers of fewer than 20 employees, can be accepted as a basis for making Medicare primary payer.

B. Employer Group Health Plan or Employer Plan (EGHP)--These terms mean any health plan that is of, or contributed to by, an employer of 20 or more employees and which provides medical care, directly or through other methods such as insurance or reimbursement to current or former employees, or to current or former employees and their families. This includes a multiemployer group health plan that has at least one employer with 20 or more employees. These plans may identify members who are employees of employers with fewer than 20 employees. Such members and their spouses are considered not to meet the conditions in §253.3.

The Federal Employees Health Benefits program meets this definition of an EGHP.

Assume in the absence of evidence to the contrary, that any health plan (including a union plan) in which a beneficiary is enrolled because of the beneficiary's or the beneficiary's spouse's employment meets this definition.

NOTE: Medicare is secondary to EGHP coverage only if the EGHP coverage is by reason of the employee's current employment. Health insurance plans for retirees or the spouses of retirees do not meet this condition and are not primary to Medicare.

C. Secondary.--For purposes of this instruction, the term "secondary" when used with respect to Medicare payment, means that Medicare is the residual payer to all EGHPs under which the Medicare beneficiary is covered by reason of current employment and will not pay for any expenses that are reimbursable by any such plan or plans. Consider the workers' compensation exclusion (§250) and automobile and liability insurance provisions (§252) must also be taken into consideration in determining the extent of Medicare's liability as a residual payer since in some cases there may be a primary insurer in addition to the EGHP.

D. Age 65 through 69.—Means a period beginning with the first day of the month in which an individual attains age 65 and ending with:

1. For services furnished on or after July 18, 1984, the last day of the month before the month the individual attains age 70.

2. For services furnished before July 18, 1984, the last day of the month in which the individual attains age 70.

An individual attains a particular age on the day preceding his or her birthday.

253.3 Individuals Subject to Limitation on Payment .—Medicare is secondary payer for Part A and Part B benefits under this provision for an individual who:

A. Is age 65 through 69, and

B. Is entitled to Part A (hospital insurance) of Medicare on the basis of the individual's own social security earnings record, or Federal quarters of coverage, or the earnings record or the Federal quarters of coverage of another person, and

C. Is either

1. Employed and covered by reason of the person's current employment by an EGHP; or

2. The spouse of an employed person, covered by an EGHP by reason of that person's employment, and the employed person is:

a. For services on or after January 1, 1985, any age through 69; or

b. For services before January 1, 1985, age 65 - 69.

253.4 Individuals Not Subject to the Limitation on Payment.—Medicare is not secondary payer for:

A. Individuals entitled, or who could upon application become entitled, to Medicare under the ESRD provisions i.e., individuals who meet the requirements for ESRD entitlement even though their current Medicare entitlement may be on the basis of age 65. (See §264 for secondary Medicare payment instructions where an ESRD beneficiary under age 65 has employer group health plan coverage.)

B. Individuals who are enrolled in Part B only.

C. Age 65-69 spouses of employees over age 69.

D. Individuals covered by a health plan purchased by the individual privately, i.e., not as a member of a group.

E. Employees of employers of fewer than 20 employees.

F. Members of multiemployer plans who have been identified as employees of employers with fewer than 20 employees.

G. Retired beneficiaries (other than spouses of employed individuals) who are covered by EGHPs as a result of past employment and do not have EGHP coverage as the result of current employment.

253.6 Identification of Individuals Subject to This Limitation on Payment.—In order to obtain the information needed to ascertain whether to bill an employer plan as primary payer, ask all Medicare beneficiaries age 65 through 69 admitted for inpatient or outpatient care, selected questions from the list of questions in §341.

If based on the information obtained in response to the questions in §341 the criteria in §253.3 appear to be met, bill the employer plan first. (See §253.8.) If Medicare is determined to be the primary payer, annotate the Medicare billing form to that effect.

253.7 Identification of Prior Claims that May Involve Employer Plan Payment.—Whenever you determine that an individual's EGHP should be billed as primary payer, search your records for any services or items furnished that individual during the 12-month period prior to the month in which the current claim is being processed but no earlier than January 1, 1983. Where such prior services or items are identified, bill the current EGHP for the prior services or items (unless the information available to the HHA about the prior services or items clearly shows why the EGHP should not be billed as primary payer). When EGHP payment is received for the prior services or items, submit an adjustment bill to the intermediary per §497.

Intermediaries may also identify prior claims for services or items furnished on or after January 1, 1983, to individuals who meet the criteria in §253.3, and on which primary benefits were paid. Where such a prior claim is identified, the intermediary will instruct the provider to bill the EGHP identified in the current claim for the prior services or items (unless the information available to the intermediary on the prior claim clearly shows why the EGHP should not be billed as primary). The provider will then submit an adjustment bill when the EGHP payment is received.

253.8 Action by HHA Where Employer Group Health Plan is Primary Payer.—

A. General.—Seek reimbursement from the EGHP before billing Medicare whenever there is indication that an employer plan is primary payer, i.e., where the services or items were rendered to an individual who meets the criteria in §253.3, and there is no evidence that the definitions in §253.2 are not met.

B. Submittal of Bill to Medicare after Employer Plan Has Made Payment.—If an EGHP pays primary benefits to a HHA, secondary Medicare benefits may be payable in accordance with §253.12 to supplement the amount paid by the EGHP. If the EGHP primary payment for a particular service or item is (1) less than your charges for Medicare covered services, (2) is less than the gross amount payable by Medicare (as defined in §253.12) and (3) you are not obligated to accept the EGHP payment as payment in full, submit a bill for secondary benefits in accordance with §497. If the EGHP payment equals or exceeds the gross amount payable by Medicare (as defined in §253.12), or equals or exceeds your charges for Medicare covered services or you are obligated to accept the EGHP payment as payment in full, no bill should be submitted. Any excess of the EGHP payment over the gross amount payable by Medicare is not subtracted from your Medicare reimbursement. If the EGHP denies your claim for primary benefits, submit a claim for primary Medicare benefits. (See §253.11.)

C. There may be instances where Medicare is secondary payer to more than one primary insurer, e.g., an individual who meets the criteria in §263.3 is covered under his own EGHP and under the EGHP of an employed spouse who meets the criteria in §263.3. In such cases, the other insurers that are primary to Medicare will coordinate benefits. If a portion of the Medicare gross amount payable remains unpaid after the others have paid primary payments, a secondary Medicare payment may be made per §497C3.

253.9 Crediting Expenses Toward Deductible and Coinsurance Amounts.—Expenses that would serve to meet the beneficiary's Part A or Part B cash or blood deductibles if Medicare were primary payer, are credited to those deductibles even if the expenses are reimbursed by an EGHP. This is true even if the EGHP paid the entire bill and there is no Medicare benefit payable. Also, EGHP payments to an HHA will be applied to satisfy a beneficiary's obligation to pay a Part A or Part B coinsurance amount.

253.10 Limitation on Right of HHA to Charge a Beneficiary.—An HHA may not charge a beneficiary or any other party for Medicare covered services if the HHA has been paid by an EGHP an amount which equals or exceeds any applicable deductible or coinsurance amount. (See Example (1) of §497C3.)

253.11 Employer Plan Denies Claim for Primary Benefits.—Where an EGHP denies a claim for primary benefits for services or items rendered an individual who meets the criteria in §253.3, the HHA should submit a claim for Medicare primary benefits. The Medicare claim must be annotated with the reason for denial of primary benefits by the EGHP. The EGHP may deny primary benefits for a variety of valid reasons; e.g., the employer does not employ 20 or more employees, the time limit for filing has expired, or the services are not covered under the EGHP. If the only reason for denial is the allegation that the EGHP is secondary to Medicare, conditional Medicare benefits will be paid subject to possible action against the insurer and employer by HCFA. See §496F for appropriate remarks to be entered on the billing form.

253.12 Amount of Secondary Medicare Payments Where Employer Group Health Plan Pays in Part for Visits and Services.—If an EGHP payment is (1) less than an HHA's charges for Medicare covered services or items and (2) less than the gross amount payable by Medicare (as defined below), and (3) the HHA is not obligated to accept the EGHP payment as payment in full, Medicare secondary payment can be made. The Medicare secondary payment is the lower of:

A. The gross amount payable by Medicare minus the amount paid by the EGHP for Medicare covered services; or

B. The gross amount payable by Medicare minus any applicable deductible or coinsurance amount.

The gross amount payable by Medicare is the current interim reimbursement amount (as defined in §498) for services reimbursed on a reasonable cost basis without considering the effect of the Medicare deductible or coinsurance or the payment by the EGHP.

Detailed reimbursement and billing instructions are in §497.

253.13 Action by Intermediary to Recover Incorrect Payments.--If primary Medicare benefits are paid to an HHA and the intermediary learns that the services or items are covered under an EGHP, the intermediary will either recover directly from the EGHP or from the HHA. When recovering from a HHA, the intermediary will instruct you to file a claim with the EGHP for primary benefits, and upon receipt of the EGHP payment to refund to Medicare the amount Medicare paid less the amount received from the EGHP.

After the intermediary instructs you to file a claim for primary benefits with an EGHP, the intermediary will follow up periodically with you to ascertain whether a claim has been filed and whether payment has been made by the EGHP. If you do not file a claim for primary benefits within 30 days after you have been instructed to do so, the intermediary will recover the Medicare primary payment from you subject to the overpayment recovery tolerance of $50, except where the reason you do not file a claim with the EGHP is because the beneficiary declines to sign the claims form. In that case, the intermediary will recover the overpayment directly from the EGHP.

Upon receipt of the EGHP refund, submit an adjustment bill showing the revised Medicare liability. When you receive an EGHP refund, credit amounts paid by the EGHP toward the deductible and coinsurance to the beneficiary's account or return to the beneficiary the amounts of the Medicare deductible and coinsurance already paid. You may retain any excess EGHP payment over the gross amount payable by Medicare (See §253.8B.)

If duplicate payment was or will be made to an HHA, i.e., the HHA received or expects to receive both primary EGHP payments and primary Medicare benefits, the intermediary will seek to recover from the HHA the Medicare overpayment which is the difference between the Medicare primary payment and the amount Medicare should have paid as secondary payer, subject to the overpayment recovery tolerance of $50. If Medicare paid the HHA and the EGHP paid the beneficiary, the beneficiary is liable.

253.14 Incorrect EGHP Primary Payments.--Cases may arise where an EGHP has incorrectly paid you primary benefits. Where such cases come to the intermediary's attention, it will instruct you to bill Medicare as primary payer and to refund to the EGHP any amount it paid in excess of the Medicare deductible and coinsurance amounts and charges for non-covered services.

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Appeals of Payment Determinations

255. HOME HEALTH AGENCY PROTEST OF PAYMENT DETERMINATIONS

The home health agency and its intermediary should attempt to resolve mutually any differences involving payment for services that arise from the application of the cost formula or the amount payable in a specific case. (See Provider Reimbursement Manual §§ 2426ff., for instructions concerning providers' rights to request a hearing on disputed cost reports.)

256. HHA'S RIGHT TO APPEAL INITIAL DETERMINATION UNDER THE WAIVER OF LIABILITY PROVISION

Section 1879(d) of the Act establishes that the provider has a right to challenge through the appeals process and the courts an intermediary's decision that items or services furnished after October 30, 1972, are not covered because they are not reasonable and necessary or constitute custodial care (§ 1862(a)(1) or (9)). If a beneficiary is partially liable for the noncovered items or services,the intermediary must first establish that the beneficiary will not exercise his appeal rights. (See § 257.) If the beneficiary chooses not to appeal,the provider has the right to appeal both the coverage and waiver of liability decisions. However, a provider does not have a right to appeal when neither the beneficiary nor the provider is liable, e.g., when the entire noncovered portion of the stay is paid under § 1879. This means that the provider may appeal an initial determination that (1) items or services are not covered because they are not reasonable and necessary or constitute custodial care, and (2) either the beneficiary or the provider knew or could reasonably have been expected to know that such items or services were not covered provided that the beneficiary does not exercise his appeal rights.

If the beneficiary appeals such initial determination, then the provider is made a party to the appeals determination.

256.1 Situations Where HHA May Initiate Appeal.-- A provider may initiate an appeal only if the ultimate liability rests with the provider or with the beneficiary and it has been determined that the beneficiary will not exercise his appeal rights. A determination will be made that the beneficiary will not exercise his appeal rights if (1) the beneficiary's liability was not waived for a portion of the items or services and the beneficiary or his representative has stated in writing that he does not intend to request a reconsideration; or (2) the beneficiary's liability was entirely waived in the initial determination.

257. BENEFICIARY PROTESTS AND APPEALS OF PAYMENT DETERMINATIONS

A. Hospital Insurance Program.--An individual dissatisfied with any determination of the amount of benefits payable on his behalf under hospital insurance may have his claim reconsidered. If he is not satisfied with the reconsideration determination and the amount in controversy is $100 or more, he may request a hearing by an Administrative Law Judge of the Bureau of Hearings and Appeals. If he disagrees with the Administrative Law Judge's decision, he may request that the Appeals Council review the decision. If still dissatisfied with the final decision of the Administration, and the amount in controversy is $1,000 or more,the individual may initiate action for Federal court review of the claim.

1. Prohibition against Beneficiary Representation by a Home Health Agency.- A home health agency or its employees should not seek to represent both a beneficiary and its own interests in pursuing a claim through the Part A appeals process. In instances where providers have no appeal rights under section 1879 of the Social Security Act and implementing regulations , some providers have sought to obtain certain appeal rights by having the beneficiary appoint the provider as his or her representative. This issue has arisen in some cases where all denied services have been paid for under the waiver of liability provision but the provider is interested in challenging the adverse coverage determination.

A home health agency may not represent a beneficiary in appealing claims denied under Part A. Section 1879(d) narrowly defines the appeal rights of providers and limits them to those instances in which the beneficiary does not exercise his appeal rights; only then may the provider step into the shoes of the beneficiary to obtain the appeal rights specified in section 1869(b) (See §262.2). Allowing a provider to represent beneficiaries whose claims have been denied would permit a new and alternative avenue of provider appeals rights clearly not authorized under section 1879 and not in accordance with Congressional intent.

A home health agency should not encourage a beneficiary to designate a provider or its employee as a beneficiary's representative for purposes of pursuing an appeal. A provider may appeal a section 1862a(1) or (9) denial only in accordance with section 1879. If a beneficiary requests you to act on his or her behalf, inform the beneficiary that you are not eligible to be appointed as his or her representative, and suggest that the beneficiary appoint a representative unrelated to the provider.

B. Medical Insurance Program.-- An individual dissatisfied with the denial of a request for payment of Part B benefits or the amount of such beneifts paid, is entitled to a review by the intermediary. If dissatisfied with the promptness with which his initial request for payment is acted upon or with the out come of the review determination,he is entitled to a hearing by a hearing officer of the intermediary. Since the home health agency is paid for the medical services it furnishes by the same intermediary that makes hospital insurance payments to the home health agency, this intermediary is responsible for the review and hearing under medical insurance. A claimant's right to a Part B hearing is dependent upon a showing that there is $100 or more in controversy.

A patient dissatisfied with a payment for the services of a provider-based physician is entitled to a review by the carrier to which the bill for the physician's services was submitted for payment. If still dissatisfied, he is also entitled to a fair hearing by the carrier.

C. HHA and Social Security Office Role in Beneficiary Protests.-- Patient protests concerning entitlement to health insurance benefits or the denial, amount, or promptness of payment for items or services furnished by the home health agency under hospital or medical insurance, if simply amenable to explanation or correction, should be handled by the home health agency. If he is still dissatisfied, the patient should be referred to his Social Security office. The Social Security office can offer assistance to the beneficiary in determining his appeal rights and can answer specific questions about the appeal procedures. The Social Security office can also assist the individual in completing the necessary forms for requesting reconsideration or hearing.

258. REOPENING AND REVISION OF MEDICARE CLAIMS DECISIONS

An initial or revised determination on a Part A or Part B Medicare claim may be reopened for any reason (and revised if found to be incorrect) within 1 year after the date of the decision.

After 1 year but within 4 years after the date of the initial decision, a determination may be reopened for "good cause," i.e., because (1) new and material evidence is furnished, (2) a clerical error has been made, or (3) there is an error on the face of the evidence; i.e., on the basis of all of the evidence on file at the time the decision was made, it is clear that the decision was incorrect.

A determination may be reopened at any time, if (1) the decision was procured by fraud or similar fault; or (2) correction of a clerical error or an error on the face of the evidence would made the decision more favorable to the claimant.

Limitation on Liability of Beneficiary and Provider Where Medicare Claims Are Disallowed

260. WAIVER OF LIABILITY FOR PROVIDER CLAIMS UNDER PART A AND B OF THE MEDICARE PROGRAM--GENERAL

The Social Security Amendments of 1972 created section 1879 of the Act to provide relief for a beneficiary who acted in good faith in accepting services found to be not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or to constitute custodial care. In such situations, the beneficiary is not liable for the charges for the services. Liability falls on the provider if it is determined the provider knew, or could reasonably have been expected to know, that the items or services provided were not covered under Medicare. However, the Medicare program will accept liability, i.e., will make payment to a provider even though a noncovered service is involved, if neither the beneficiary nor the provider knew or could reasonably be expected to have known, that the services were not covered under Medicare.

This provision applies only to items or services furnished after October 30, 1972. It does not apply to any services rendered by a provider prior to the date on which its Medicare agreement is accepted by the Secretary, even though the effective date of the agreement may be earlier. This is so because a beneficiary dealing with a nonparticipating provider could not reasonably have expected Medicare coverage.

Section 1879 establishes that a provider may appeal a determination that services were not reasonable or necessary or constitute custodial care when it is determined that liability rests entirely with the provider, or when the beneficiary is partially or completely liable for the noncovered items or services and it has been determined that the beneficiary will not exercise his appeal rights (see § 256). Section 1879 also provides that the Medicare program will indemnify (i.e., make direct payment to) (see § 269) the beneficiary or other person(s), subject to the deductible and coinsurance amounts, for any payments made by the beneficiary or other persons to a liable provider that are not refunded or credited, for items or services which have been determined to be noncovered, as specified in § 261 below. Any payments made as indemnification shall be treated as overpayments to such provider and withheld from future Medicare benefits due that provider. (See § 269.3.)

NOTE: Sections 261 through 267 discuss specific procedures for implementing this provision with regard to provider claims for Part A and Part B HHA claims billed on form SSA-1487. Section 268 discusses procedures for processing medical and other health services usually billed on form SSA-1483.

261 APPLICABILITY OF LIABILITY TO ITEMS OR SERVICES FURNISHED BY PROVIDERS OF HOME HEALTH SERVICES BILLED ON FORM SSA-1487

A. The waiver of liability provision applies to denials under only two specific statutory exclusions from coverage;

1. Items or services that are not reasonable and necessary for the diagnosis or treatment of illness, injury, or to improve the functioning of a malformed body member (excluded by section 1862(a)(1)). (See section 232.1.)

2. Items or services that constitute custodial care, i.e., not a covered level of care (excluded by section 1862(a)(9)). (See section 232.10.)

This waiver of liability provision does not apply to claims denied for any other reason.

B. The following examples illustrate types of denials which cannot involve the waiver of liability provision and for which no payment can be made.

1. Services payable under State or Federal worker' compensation.

2. Services denied because the patient is not homebound.

261.1 Prior Inpatient Stay Requirement for Coverage of Home Health Services Under Part A as Related to Waiver of Liability.—Coverage of home health visits under Part A is subject to a spell of illness provision and a prior inpatient stay requirement. To meet the prior inpatient stay requirement, the home health visits must take place in the year following the most recent discharge from a covered SNF stay of any duration or from a qualifying hospital stay of at least 3 consecutive days (see section 210.2). If the beneficiary's liability was waived for either an SNF or a hospital stay, the inpatient days for which liability was waived cannot be used to satisfy the home health inpatient stay requirement. Effective July 1, 1981, the prior inpatient stay requirement under Part A is eliminated.

262. DETERMINING LIABILITY FOR PROVIDER CLAIMS UNDER SECTION 1879—GENERAL

Whether a beneficiary or a provider knew or could reasonably have been expected to know that items or services were not covered is often a judgmental issue which would be difficult and costly to decide without the use of administrative presumptions. For this reason, decisions as to the waiver of liability on provider claims normally will not be developed case-by-case, but will be made on the basis of certain presumptions.

262.1 Determining Beneficiary's Liability.—For the beneficiary, the presumption will be made that he did not know that services would not be covered unless the evidence indicates that notice was given to the beneficiary. In some cases, the beneficiary may have been given notice in a previous claim that a type of care would not be covered. More commonly, the provider will have given notice to the beneficiary that a particular course of treatment would not be covered or that coverage ended at a particular time.

A. Beneficiary Determined to be Liable.—When the intermediary determines that the beneficiary is liable, the beneficiary is held responsible for the payment or expenses incurred for items or services determined to be noncovered under Medicare.

B. Beneficiary Determined to be Without Liability.—Unless evidence indicates that the beneficiary knew or had reason to know that the items or services he received were noncovered because they were not reasonable or necessary, the intermediary will presume that the beneficiary did not know the services would not be covered.

When the beneficiary's liability is waived, all visits for which he received benefit of waiver (whether or not Medicare payment is made) will be charged to the beneficiary's utilization record of visits, as though covered under Medicare. Such visits will be shown as having been used on the utilization notice, form HCFA-1533. This requirement includes visits for which the beneficiary's liability has been waived but for which the provider is liable.

262.2 Determining Provider Liability.—

A. General.—A provider will be held liable for noncovered services if it is determined that the provider:

1. had actual knowledge of the noncoverage of services in a particular case, or
2. could reasonably have been expected to have such knowledge.

When a provider makes all reasonable efforts to assure its Medicare coverage decisions are correct and demonstrates the ability to make accurate Medicare coverage decisions, it will be presumed that the provider did not have knowledge of noncoverage.

As a means of determining whether a provider is entitled to a favorable waiver presumption, a denial rate criterion has been established which is intended to indicate whether a provider can make accurate judgments concerning the coverage or noncoverage of services in most cases. If a provider does not meet the denial rate criterion it will not be considered to have taken all reasonable measures to obtain knowledge of noncoverage and therefore will not be granted a favorable waiver presumption.

Where an HHA meets the criterion (see SS 263ff.), all of its claims for Part A and B home health agency visits will be processed under the presumption that it had no knowledge of noncoverage unless the evidence in a particular case shows that, in fact, it had such knowledge. When an HHA does not meet the criterion, the presumption is not applicable and the HHA's liability will not ordinarily be waived in cases denied as not reasonable or necessary. However, even though an HHA has been found not to meet the criterion, and a presumption cannot be extended to its cases, the HHA may allege that in an individual claim it did not know and could not have been expected to know that the care could not be covered. In such situations, the intermediary will consider the evidence submitted in support of the allegation.

The presumption applies to all categories of claims. Distinctions will not be made by category, except that when an HHA has been advised either by intermediary bulletins or by denial of a prior claim that a specific modality of services that it renders is not considered reasonable and necessary, claims for that type of service cannot be entitled to the presumption. See SS 268ff. for discussion of waiver of liability for Part B provider services billed on HCFA-1483.

B. Provider Is Determined to Be Liable--Right to Appeal.-- A provider who is determined liable for all or a portion of the charges for noncovered items and services furnished a beneficiary may appeal such a decision by an intermediary under certain conditions (see S256).

NOTE: The waiver of liability provision does not apply to third party payors. Therefore, a provider who is determined liable may seek payment from a third party payor without being subject to recovery action that could occur if it sought payment from the beneficiary.

C. Provider and Beneficiary Determined to Be Without Liability.-- If the intermediary determines that neither the provider nor the beneficiary knew or had reason to know that the services provided the beneficiary were not covered, the Medicare program will accept liability and make payment. (See S 267.)

With respect to the beneficiary, the instructions contained in SS 260-268.4 will apply in determining waiver of liability.

263. CRITERIA FOR PRESUMING THAT HHA MEETS WAIVER OF LIABILITY REQUIREMENTS

To determine whether an HHA has knowledge of Medicare coverage rules and can apply them, intermediaries will collect statistics to ascertain whether each HHA's denial rate does not exceed 2.5 percent (see S 263.3 for determining the HHA's denial rate.).

For purposes only of determining an HHA's presumptive waiver of liability status, compliance with the following criteria are deemed met if the HHA meets its applicable denial rate: (1) the certification/recertification requirements in 90 percent of the cases reviewed; (2) procedures that assure that bills and medical documentation are submitted in a timely manner; and (3) procedures which assure timely HHA notice to beneificares.

263.1 Reevaluating and Notifying HHA's-- Each HHA must be reevaluated at least every 3 months to determine whether it is entitled to a favorable waiver presumption. The intermediary may set a shorter time for reevaluation in special situations where an HHA or a group of HHAs has drastic fluctuations in its denial rates.

The intermediary is to notify the HHA in writing when there is a change in its presumptive status.

263.2 Reevaluating HHA's Presumptive Waiver of Liability Status for a Prior Period.-- Occasionally, new information may indicate that an earlier determination that a HHA qualified for presumptive waiver of liability status was erroneous. In such a situation, the intermediary may retrospectively reevaluate and redetermine the HHA's compliance with the requirements for a favorable waiver presumptive for a prior period.

If the reevaluation of the HHA's compliance so establishes, the intermediary may determine that the HHA had, or could reasonably have been expected to have had knowledge of the noncoverage of the services for claims denied as not being medically reasonable and necessary during the prior period in question.

Even though the intermediary determines after reevaluation, the HHA was in compliance with the appropriate denial rate criterion, it may rebut the HHA's favorable presumption in any individual case in which the evidence is clear and obvious that the HHA should have known at the time the services were furnished that they were not covered.

263.3 Determining Denial Rates for HHA's.-- Specified data will be recorded for each HHA for those cases reviewed in which a Medicare beneficiary receives services prior to an event terminating program coverage. Terminating events include: (1) HHA notice; (2) intermediary notice; (3) exhaustion of benefits; (4) discharge; or (5) death.

The intermediary records the following data:

A. All visits (excluding "grace day" visits under § 1879) determined by the HHA to be covered. All visits will be considered to have been determined covered by the HHA if they are billed as covered by the HHA or if they were incurred prior to a terminating event.

B. All visits determined by the HHA to be covered but determined by the intermediary to be noncovered because the services provided were not medically necessary and reasonable.

NOTE: Visits denied for other reasons than Sections 1862(a)(1) or (9) should not be included in either A. or B..

The denial rate is calculated by dividing "A" into "B." For the denial rate criterion to be met the number of visits in "B" must not exceed 2.5 percent of the number of visits in "A."

263.5 Time Period for Calculating HHA Denial Rate.-- Each calendar quarter, or more frequently if it is believed necessary, the intermediary calculates each HHA's denial rate based on the data collected for that HHA during the preceding calendar quarter. The denial rate will be calculated by the end of the month following the end of the quarter.

For example, data compiled during 1/1 through 3/31 is used to calculate the HHA's denial rate. This calculation is made by 4/30. If shorter time, e.g., 1 or 2 month periods are used, the principles above are adapted to the shorter times.

263.6 Effect of Changes in HHA Waiver Status.-- Intermediaries will advise the HHA of any changes in its waiver status by the end of the month following the end of the quarter for which the denial rate was calculated.

For example, if there is a change in a HHA's status based on data compiled from 1/1 through 3/31, the HHA retains its former presumptive status for services rendered from 1/1 through 3/31 and up to the date of the intermediary's notice of change of presumptive status, but no later than the last day of the month following the end of the quarter (in this case 4/30).

All claims processed involving services on or after the date of notice will be processed under the new presumptive status.

263.7 Treatment of Visits Initially Denied But Later Reversed.-- Visits initially denied as noncovered but later determined to be covered, i.e., as a result of a reconsideration, hearing, or reopening and revision are to be subtracted from the provider's denied Medicare visits. The subtracting of such visits will be applied to the period during which the reversal action occurred.

NOTE: Visits payable only under the waiver of liability provision are considered noncovered visits and would not be counted as covered in the denial rate calculations.

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265. DETERMINING WHETHER HHA HAD KNOWLEDGE OF NONCOVERAGE OF SERVICES

A HHA will be considered not to have had knowledge of noncoverage of services in a particular claim unless there is evidence to the contrary. Such evidence to the contrary may include the following:

A. Waiver Criterion--The HHA did not meet the criterion for a favorable presumption;

B. HHA Notices

1. The HHA submitted a no-payment claim, or submitted a claim for payment only at the request of the beneficiary;

2. The HHA issued a written notice of noncoverage to the beneficiary.

C. Medicare Bureau Directives--

The Medicare Bureau has informed the HHA in writing of the noncoverage of a particular service or category of services. For example, specific instructions in §§ 232ff. provide examples of unskilled services excluded from Medicare coverage. Thus, where it is clear and obvious from review of a particular medical record that the patient received only excluded services the HHA is expected to have knowledge of noncoverage.

D. Intermediary Notices

1. A one-time written notice from the intermediary to the HHA that a particular item or service is not covered (e.g., acupuncture) is sufficient notice for all subsequent claims involving that service.

2. The intermediary notified the HHA by telephone and/or in writing that the care is not covered or that covered care has ended. The date of the telephone notice is the effective date of notification to the HHA.

3. The intermediary issued a general provider bulletin or newsletter advising that a specific item or service is not considered reasonable and necessary.

E. Medical Information

1. A physician clearly indicated in the patient's medical record that the patient no longer needed the services provided. The HHA is accountable for information found in the patient's medical records, such as the patient's medical chart, attending physicians' notes, or similar records, since these are HHA records. The HHA's favorable presumption may be rebutted on the date the evidence, based upon medical records such as that described below, clearly indicates noncoverage of services:

a. A physician indicated the patient could be discharged from a home health plan of treatment; or

b. The attending physician refused to certify or recertify to the patient's need for home health service covered by Medicare because he determined that the patient's condition does not require such services.

2. The intermediary will follow its established procedure for requesting additional evidence needed in a particular case to permit a decision on coverage. Where the beneficiary is still receiving treatment, the HHA will be advised that the additional information must be submitted (i.e., postmarked), within 5 work days of a telephone request, or if a telephone request is not feasible, postmarked within 7 work days of the date of a written request.

If this requirement is met, and the HHA has presumptive waiver status, it is protected from liability under the provision through the date the intermediary makes its coverage determination based on the requested additional evidence and notifies the HHA. If the evidence is not submitted within the required 5 to 7 days, the HHA is protected from liability under the waiver only through the date the intermediary requested the additional evidence, even though the HHA otherwise has presumptive status.

265.1 Notifying Patient of Noncoverage.--Where an HHA authorised to give notice of noncoverage under condition as set forth in § 266A below, is aware that the services to be furnished to a patient will not be covered, it should advise the patient (or his representative) in writing prior to or at the time of start of care (or at the time the type of care changes) that the care is noncovered and that no claim for Medicare reimbursement will be submitted. If the beneficiary insists that the provider submit a claim for payment, the HHA should indicate that the bill is being submitted at the beneficiary's request, and why the HHA considers the care to be noncovered. The no-payment billing procedures should be used (see § 430). In such a case, neither the beneficiary nor the HHA would be entitled to a waiver of liability. (Such denials will not be counted in determining denial rates for application of the criteria in § 263.3 but statistics will be kept to determine whether the criteria in § 263.4 continues to be met.)

HHAs should have an established procedure for notifying beneficiaries and physicians promptly when a decision of noncoverage is made. The procedure should provide for a written notice of noncoverage to the beneficiary or person acting on his behalf on the day that home health services were to be started or on the day the care is found to be noncovered by the HHA, or on the same day the intermediary telephones a decision of noncoverage to the HHA.

265.2 Improper HHA Coverage Decisions.--The intermediary will review cases which the HHA considers noncovered and has asked the intermediary for a determination. If in a substantial number (in excess of 5 percent the intermediary finds that covered services are involved, it will infer that the HHA does not know the standards for coverage and is not in a position to give effective notices of noncoverage to beneficiaries. In such cases, the HHA will be denied the presumption for waiver of liability.

266. ESTABLISHING WHEN BENEFICIARY IS ON NOTICE OF NONCOVERAGE

If the beneficiary has previously been informed that services were noncovered as a result of a prior stay for the same condition, the beneficiary would be liable for payment for the services based upon the prior notice, but only if it is clear that the beneficiary (or the person acting on his behalf) should have known that the circumstances were the same as in the situation previously found to be noncovered. With this exception, the beneficiary will be presumed not to have known nor to have been expected to know that care would not be covered unless or until one of the following occurs with respect to the beneficiary or the person on his behalf:

A. HHA Is Source of Notice

1. An HHA which meets the denial rate criterion advised the beneficiary or the person acting on his behalf in writing prior to start of care that the care is noncovered.

NOTE: Generally an HHA that does not meet at least the denial rate criterion may give a valid written notice to the beneficiary that care is not covered only where Medicare Bureau instructions or the intermediary's general issuances have clearly defined a service as noncovered. For example, when a supportive or unskilled service specifically listed as noncovered is the only service to be rendered, such as HHA's written advice to the patient upon start of care that Medicare does not cover the service is considered notice and the beneficiary is not entitled to waiver of liability. In such a case, the HHA submits a no-payment bill to the intermediary or, if the beneficiary insists that the HHA bill Medicare, the HHA submits a no-payment claim with a statement explaining the situation.

2. During the course of the patient's plan of treatment, the HHA is advised by the intermediary that covered care has ceased and the HHA notifies the beneficiary or the person acting on his behalf in writing of the intermediary's determination.

3. During the patient's plan of treatment, an HHA which meets the denial rate criterion advised the patient or the person acting on his behalf in writing that the patient no longer required covered care.

4. The beneficiary's first notification of noncoverage is received from the intermediary (e.g., intermediary denial notice).

266.1 Determining Date of Notice.--

A. For Beneficiaries.--In determining when the beneficiary received knowledge of noncoverage, the date of the written notice will be used when the beneficiary is under a plan of treatment and is capable of handling his own affairs (i.e., able to sign and negotiate checks).

Home health agencies which are unable to deliver notice of non-coverage personally to a beneficiary should give notice by telephone and on the same day should mail a written confirmation of the telephone notice. The date of the telephone call is considered the date the beneficiary received notice of noncoverage.

B. For HHAs.--Where an HHA is notified of noncoverage by an intermediary, the intermediary uses the date annotated in its records in accordance with § 265D.

Where the HHA itself determines that covered care is no longer required, the intermediary uses the date of the HHA's written notice to the beneficiary of such noncoverage, as indicated in A above.

266.2 Documentation of Notice.--It is very important that HHA be aware of these definitions of notice.

HHA should retain copies of all notices of noncoverage they have given to beneficiaries, because the fact of notice to the beneficiary may be an important element in the event of an appeal on the issue of waiver of liability.

267. PAYMENT UNDER WAIVER OF LIABILITY

When it is determined during a beneficiary's course of visits that the care is not covered but both the beneficiary and the HHA are entitled to waiver of liability, the Medicare program may make payment for the noncovered services for a grace period of 1 day (24 hours) after the date of notice to the HHA or to the beneficiary, whichever is earlier. (See §§ 265 and 266 for definition of notice.) If it is determined that more time is required in order to arrange postdischarge care, up to 2 additional "grace period" days may be paid for.

When the HHA is given notice as described above, the HHA is required to advise the beneficiary in writing of the determination made. The HHA's written notice to the beneficiary should be given on the same date it received notice from the intermediary. Where the HHA fails to give the beneficiary such timely notice, the beneficiary is protected from liability until he received the notice. For example, if an HHA received notice of noncoverage from the intermediary on February 15 but failed to advise the beneficiary until February 19, the beneficiary would be protected from liability through February 19--the date on which he first received notice. However, the HHA would be entitled to program payment only through the date--February 15--on which it received notice, and for whatever "grace period" is allowed thereafter. In a case in which an HHA received notice from the intermediary on February 15 but failed to give the beneficiary notice until the next day--February 16--the beneficiary and HHA would be protected from liability under the "grace period" only for the additional day--February 16--unless it is determined that more time is required to arrange postdischarge care, in which case up to 2 additional "grace period" days may be paid for.

268. APPLICABILITY OF THE WAIVER OF LIABILITY PROVISION TO HOME HEALTH CARE CLAIMS BILLED ON FORM HCFA-1483

The waiver of liability provision, i.e., section 1879 of the Act, will be applied to claims involving Part B services billed on a Provider Billing for Medical and Other Health Services, Form HCFA-1483. The intermediary will determine whether waiver of liability applies to these categories of claims when the basis for the denial is that services were not reasonable or necessary (under section 1862(a)(1) of the Act).

268.1 Determining Beneficiary Liability .--A presumption will be made that the beneficiary did not know that items or services would not be covered unless there is evidence to the contrary. Indication in the claim file that the beneficiary received notice prior to receiving the noncovered services would be evidence to the contrary and would rebut the presumption in the beneficiary's favor. The definitions of "notice" to the beneficiary set fort in § 266 should be followed.

268.2 Determining Provider Liability.--The application of the waiver of liability provision to a provider of these services will depend upon whether the provider has met the denial rate criterion and qualifies for a favorable waiver presumption for its services billed on form HCFA-1487. As with HCFA HHA claims, to have its liability waived under Part B, the provider has to establish in an individual claim that it did not know and could not have been expected to know that the items or services would not be covered.

A. HHA Entitled to Favorable Waiver Presumption.--Where a provider is entitled to a favorable waiver presumption for Part A and B home health agency visits billed on form HCFA-1487, that presumption extends to its claims for services payable under Part B (billed on form HCFA-1483). That provider's claims will be processed under the presumption that the provider did not know or have reason to know that these services were not covered. If it is determined that the provider is submitting an excessive number (see § 268.3) of noncovered HCFA-1483 claims and the noncovered claims relate to a particular service, such as physical therapy services, the presumption in favor of waiver of liability will be withdrawn for that type of service rather than for all categories of its services normally billed on form HCFA-1483.

B. Provider not Entitled to Favorable Waiver Presumption.--If the HHA does not have a favorable waiver presumption with respect to its claims filed on form HCFA-1487 it cannot receive a favorable waiver presumption for its claims filed on form HCFA-1483. An HHA may have its liability waived in an individual claim if it can establish that it did not know and could not have been expected to know that the items or services would not be covered.

268.3 Withdrawal of Waiver Presumption.--If the intermediary determines that a provider has submitted an excessive number of claims for a category of noncovered services, the provider will be advised that its favorable waiver presumption for the specific type of service is being withdrawn. The notice will specify the type of service involved. In order to reestablish the favorable presumption, the provider must show that it can distinguish effectively between covered and noncovered services for at least a three month period.

Indemnification Procedures under Waiver of Liability

269. INDEMNIFICATION PROCEDURES FOR CLAIMS FALLING WITHIN THE WAIVER OF LIABILITY PROVISION

Section 1879(b) of the Act provides that when a provider is held liable for the payment of expenses incurred by a beneficiary for noncovered items or services and such provider requests and receives payment from the beneficiary or any person(s) who assumed financial responsibility for payment of expenses, the Medicare program will indemnify the beneficiary or other person(s) less the applicable deductible and coinsurance amounts. Further, any such indemnification payments are considered overpayments to the provider.

The waiver of liability provision does not apply to third party payors, such as Medicaid. A provider who is determined liable may, therefore, seek payment for a third party payor if one exists.

269.1 Determining the Amount of Indemnification.--In accordance with § 1879(b) of the Act, the beneficiary or other person(s) will be indemnified for actual charges paid to a provider, rather than the usual allowable charges as might be determined by the Medicare program. The beneficiary will still be responsible for any unmet deductible and coinsurance (if applicable) for the items or services for which the provider has been held liable.

The intermediary, in determining the beneficiary's deductible liability will, based on its query reply, determine if any deductible is met. If any deductible remains unmet in the particular benefit period, the beneficiary is liable for that amount.

When the deductibles have been determined by the intermediary, the applicable amount will be deducted from the indemnification amount before payment is made.

269.2 Notifying the Provider.--After the intermediary has reviewed the claim for indemnification and the indemnification amount has been determined, the provider will be notified of the proposed indemnification action. The essential elements of this written notice are:

1. An explanation of the items and services for which the provider is liable with reference to the original notice to the provider;

2. A statement of the provision of § 1879 which allows the program to indemnify the beneficiary and recover an overpayment from the provider;

3. An explanation of the amount determined payable to the requester for indemnification;

4. A statement that the amount determined to be payable by the intermediary will be paid to the requester and that it constitutes an overpayment to the provider which will be recovered from future Medicare payments made to it;

5. A statement encouraging the provider to refund any amount(s) already collected; and

6. The opportunity for the provider to question the amount determined payable by the intermediary, in writing, within 15 days.

270. HHA MODEL LETTER TO ESTABLISH BENEFICIARY NOTICE OF MEDICARE NONCOVERAGE

The following section discusses a model letter that is to be used by HHAs as required by § 266, "Establishing When Beneficiary is on Notice of Noncoverage".

270.1 Instructions for Completing HHA Model Letter (Exhibit 1).—Make an original and two copies of the letter. (If the intermediary requires that it receive a copy of the letter, make one more copy.) The HHA must give or, where this is not possible, mail the original to the beneficiary (or person acting on his behalf). Send the first copy to the beneficiary's attending physician, and keep the second copy. When a copy is given a beneficiary (or person acting on his behalf) the HHA's copy should contain the signature of the beneficiary (or person acting on his behalf), acknowledging the date he received the notice. Where personal delivery is not possible, the HHA's copy should reflect the date the beneficiary was notified by telephone and the date the notice was mailed.

A. Heading of Letter

1. HHA Designation: The home health agency's name and address should appear at the top of the letter.

2. Date Line: The date the letter is given or mailed to the beneficiary or his representative is always required.

3. Address Line: Enter the name of the beneficiary (or the person acting on his behalf). If the letter will be mailed, enter the address of the beneficiary (or the person acting on his behalf). Be sure to position the name and address properly if a window envelope is used.

4. Re Line: Where the letter is addressed to a person acting on behalf of the beneficiary, always enter the name of the beneficiary. In all cases, however, enter in this space the beneficiary's Medicare number and the date of start of care.

5. Referred to Services: Specify the type and number of services referred to in the letter. For example, if the beneficiary were receiving 8 Nursing Visits per month and it has been determined that only 2 Nursing Visits per month are medically necessary, this item should indicate, "6 Nursing Visits per month".

If the beneficiary were receiving both nursing services and physical therapy services and only the nursing services were not covered, the provider should indicate "nursing services only" in this item.

If all services were determined not to be medically necessary, enter "all services" in this item.

MODEL LETTER EXHIBIT 1

NAME OF HHA
ADDRESS
DATE

TO: NAME
ADDRESS

RE: NAME OF BENEFICIARY
MEDICARE NUMBER
DATE OF START OF CARE

REFERRED TO SERVICES:____________________

The item checked below explains that the above indicated home health services which the Medicare beneficiary received or was to receive from this Home Health Agency are not covered by Medicare.

☐ 1. The medical information available at the time of, or prior to, start of care shows that the specific services to be furnished by this agency do not meet the requirements for coverage under Medicare. However, should you request the agency to file a claim with Medicare, you will receive a formal determination from the Medicare intermediary as to the noncoverage of the home health services.

☐ 2. The specific services furnished no longer qualify as covered under Medicare, beginning____________. The Medicare intermediary will send you a formal determination as to the noncoverage of the home health services.

☐ 3. The Medicare intermediary advises that the type of services furnished no longer qualify as covered under Medicare beginning ____________. The Medicare intermediary will send you a formal determination as to the noncoverage of the home health services.

The Medicare intermediary servicing this agency is (Name and address of Medicare intermediary).

☐ 4. We regret that this may be your first notice of the noncoverage of the home health services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful.

____
(Signature of Administrative Officer)

****

VERIFICATION OF RECEIPT OF NOTICE

☐ A. This is to acknowledge that I received this notice of noncoverage of services under Medicare on (date of receipt).

____
(Signature of beneficiary or person acting on behalf of beneficiary)

☐ B. This is to confirm that you were advised of the noncoverage of the services under Medicare by telephone on (date of telephone contact).

____
____
(Signature of Administrative Officer)

KEEP THIS COPY FOR YOUR RECORDS
No action on your part is required

B. Body of Letter.--Check appropriate item(s) per following instructions:

ITEM 1. Check where a home health agency meeting the denial rate criterion determines prior to, or at the start of care, that the services to be furnished the beneficiary will not be covered.

ITEM 2. Check where a home health agency meeting the denial rate criterion determines that further services to be furnished the patient will not be covered. Insert the date of the first day on which the services will no longer be covered.

NOTE: A home health agency that does not meet the denial rate criterion may check item 1 or 2 where the services to be furnished are clearly defined by Medicare Bureau instructions or the Medicare intermediary's general issuances or prior notices concerning noncovered services under Medicare. (See "Note" after § 266A.)

ITEM 3. Check where the home health agency is advised of the noncoverage of services by its Medicare intermediary. Insert the first date the home health services are no longer covered as determined by the intermediary.

After the above items, indicate the name and address of the intermediary serving the HHA.

ITEM 4. Check where an in-person or phone contact could not be made with the beneficiary or the person acting on behalf of the beneficiary. When this item is checked, the Model Letter should be mailed out on the same day as contact was attempted. (See § 266.1A.)

C. Signature of Administrative Officer.--The letter should be signed by an administrative officer of the agency or his agent.

D. Verification of Receipt.--The appropriate item should be checked and completed to verify that notice of noncoverage was issued to the beneficiary or to the person acting on behalf of the beneficiary. Only one item should be checked:

ITEM A. Check and complete where contact is made in person (i.e., this notice is personally delivered). If the beneficiary or the person acting on behalf of the beneficiary refuses to sign the verification, the provider's copy of the Model Letter should be annotated accordingly, indicating the circumstances and persons involved.

ITEM B. Check and complete where only telephone contact was made.

A203 Covered Home Health Services.--The Medicare and Medicaid Amendments of 1980:

A. provide unlimited Part A and Part B visits.

B. eliminate the 3-day prior stay and Part B deductible.

C. include occupational therapy as a qualifying criteria for home health benefits.

D. prohibit a physician who has a significant ownership interest in or significant financial or contractual relationship with the agency from performing certification and establishing a home health plan of treatment.

These changes apply to all home health treatment plans established on or after July 1, 1981.

Cross refer: Section 203

Presumed Coverage of Part A
Posthospital Home Health Services

A211. PRESUMED COVERAGE OF PART A POSTHOSPITAL HOME HEALTH SERVICES.—This provision has been rescinded, effective January 1, 1981, by section 941 of Public Law 96-499, the Omnibus Reconciliation Act of 1980.

Cross-refer: §211

Outpatient Physical Therapy and Speech Pathology Services

A219.4.E Outpatient Physical Therapy or Outpatient Speech Pathology Services Furnished Under a Plan.—Prior to the Omnibus Reconciliation Act of 1980 only a physician was permitted to establish the required plan of treatment for outpatient speech pathology services. Effective January 1, 1981, a plan of treatment for outpatient speech pathology services may be established by either the physician or the speech pathologist providing such services. Any changes to a plan of treatment established by such speech pathologist must be in writing and signed by that pathologist or by the attending physician. A speech pathologist, however, may not alter a plan of treatment established by a physician.

The requirements that a patient be under the care of a physician and that there be periodic review of the plan of treatment remain unchanged.

Cross refer: § 219.4.D and E.

Outpatient Physical Therapy and Speech Pathology Services

IM 219.4E Outpatient Physical Therapy or Outpatient Speech Pathology Services Furnished Under a Plan.—Prior to the Medicare and Medicaid Budget Reconciliation Amendments of 1984 only a physician was permitted to establish the required plan of treatment for outpatient physical therapy services. Effective July 18, 1984 a plan of treatment for outpatient physical therapy services may be established by either the physician or the qualified physical therapist providing such services. Any changes to a plan of treatment established by a physical therapist must be in writing and signed by that physical therapist or by the attending physician. A physical therapist, however, may not alter a plan of treatment established by a physician.

The requirements that a patient be under the care of a physician and that there be periodic review of the plan of treatment remain unchanged.

Cross refer: §§219.4A, 219.4.D and E

CHAPTER II - COVERAGE OF SERVICES

APPENDIX

COVERAGE ISSUES

The material in this appendix represents responses to questions about coverage of services under Medicare.

These responses are based on existing resource material and, where there are medical implications, on expert professional advice received from both Government and non-Government sources, including opinions from appropriate specialists in the medical community.

APPENDIX

COVERAGE ISSUES

Nursing Services

Home Health Visits to the Home of a Blind Diabetic HHA-1

Home Health Nurses' Visits to Patients Requiring Heparin Injections HHA-2

NURSING SERVICES

HHA-1 Home Health Visits to a Blind Diabetic

Many individuals who are blind and require daily insulin for the control of a diabetic condition are able to administer their injections without assistance (other than possibly that which may be furnished by family members or friends). There are organizations which encourage and train blind diabetics, both to fill their own syringes and to inject themselves. There are also a number of devices available for blind individuals to fill their insulin syringes accurately. However, the individuals who may need assistance with prefilling their syringes may also require periodic observation and evaluation, even though their diabetes is fairly stabilized. In such cases, probably few in number, home health services may be required for this purpose.

To qualify for home health benefits, a blind diabetic must be confined to his home, under the care of a physician, and in need of either skilled nursing services on an intermittent basis or physical therapy or speech therapy. Effective July 1, 1981, a person may qualify for home health benefits based on his or her need for occupational therapy or skilled nursing services on an intermittent basis, physical therapy or speech therapy. Effective December 1, 1981, occupational therapy is eliminated as a basis for entitlement to home health services. However, if a person has otherwise qualified for home health services because of the need for skilled nursing care, physical therapy or speech therapy, the patient's eligibility for home health services may be extended solely on the basis of the continuing need for occupational therapy. (See § 203.) There must be a plan of treatment, established and periodically reviewed by a physician, which indicates that there is a recurring need for home health services to supplement the physician's contacts with patient; e.g., skilled nursing visits for observing and determining the need for changes in the level and type of care which has been prescribed. (See § 204ff.) Once an initial regimen has been established, the frequency of need for further home health services can vary greatly from patient to patient, depending on their condition and the likelihood of its changing. Some may need visits only every 90 days, for example, while others may require them much more frequently. If a nurse makes a visit to provide skilled services and also prefills syringes, the purpose of the visit, which was to provide skilled services, does not change. However, if the sole purpose of a nurse's visit is to prefill insulin syringes for a blind diabetic, it is not a skilled nursing visit, although it may be reimbursed as such as indicated below.

Filling a syringe can be safely and effectively performed by the average nonmedical person without the direct supervision of a licensed nurse. Consequently, it would not constitute a skilled nursing service, even if it is performed by a nurse. (See § 204.2B.) The personal care duties normally performed by home health aides include assisting the patient with medications ordered by a physician which are ordinarily self-administered. (See § 206.2.) Performance of such a service by an aide is consistent with the Medicare conditions of participation for home health agencies. Therefore, home health aide services would be appropriate for those blind diabetics who are qualified for home health benefits and who cannot fill their syringes. An adequately trained home health aide could make intermittent visits, usually on a weekly basis, to the home for the purpose of filling that supply of insulin ordered by the physician.

If State law, however, precludes a home health aide from prefilling insulin syringes, payment may be made for this service as part of the cost of skilled nursing services when performed by a nurse for a blind diabetic who is otherwise unable to prefill his or her syringes. There are no adverse consequences with respect to reimbursement to the home health agency for providing the service in this manner.

If State law does not preclude a home health aide from prefilling insulin syringes, but the home health agency chooses to send a nurse to perform only this task, the visit is reimbursed as if made by a home health aide.

NOTE: As indicated above, to qualify for home health benefits, a patient must require skilled services. If a beneficiary does not qualify for home health benefits but only needs someone to prefill syringes with the correct dosage of insulin, then no program payment can be made.

Cross-refer §§ 203, 204ff, 204.2B, 206.2

HHA-2 HOME HEALTH NURSES' VISITS TO PATIENTS REQUIRING HEPARIN INJECTIONS

Professional medical advice indicates that subcutaneous injections of low dose heparin can be, under certain circumstances, medically accepted therapy for the treatment of recurrent deep venous thrombosis, recurrent pulmonary emboli, and other conditions requiring long term anticoagulation. The usual drug of choice for these conditions is warfarin. Heparin may be substituted for warfarin in circumstances such as demonstrated warfarin sensitivity. Heparin is now the drug of choice for anticoagulation during pregnancy.

Medicare payment may be made for several visits by the home health nurse to teach the patient or the caring person to give subcutaneous injections of low dose heparin if it is prescribed by a physician for a homebound patient who: (1) is pregnant and requires anticoagulant therapy, or (2) requires treatment for deep venous thrombosis or pulmonary emboli or for another condition requiring anticoagulation and documentation justifies that the patient cannot tolerate warfarin. If the patient or caring person is unable to administer the injection, nursing visits to give the injections on a daily basis, 7 days a week, for a period of up to 6 months (in the case of pregnancy, visits may be made for a period beyond 6 months if reasonable and necessary) would be reimbursed by Medicare. Coverage for these services after 6 months of treatment would be provided only if the prescribing physician can justify and document the need for such an extended course of treatment. Documentation of need for heparin injections beyond 6 months would not be required for pregnant patients who meet the homebound criteria.

Cross-refer §§ 204.4B, 204.4H.1

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300. HEALTH INSURANCE CARD

The Social Security Administration maintains in Baltimore, Maryland, the records of all persons entitled to health insurance. After entitlement is established each beneficiary is issued a health insurance card by the Social Security Administration (or in some cases by the Railroad Retirement Board) for use in obtaining hospital insurance benefits, medical insurance benefits, or both. The health insurance claim number on the card is essential in locating the patient's record when a claim for benefits payment is made. No billing form should be forwarded without the correct claim number. Exhibit 1 of §399 shows the health insurance cards, and §305 explains the numbering system as an aid in recognizing valid numbers.

The home health agency should ask each patient who gives his age as 65 or older, or a younger patient who possibly has Medicare entitlement as a disability beneficiary or under the provisions for coverage of persons needing kidney transplants or dialysis, for his health insurance card to determine his health insurance entitlement status and obtain the correct health insurance claim number. If a patient is within 3 months of age 65 and has not yet applied for health insurance entitlement, it will be helpful if he, or someone on his behalf, is advised to contact the social security office. The home health agency may wish to arrange with the social security office to bring such cases routinely to the attention of the social security office.

A health insurance card is acceptable without a signature, but the patient should be asked to sign it.

302. CERTIFICATE OF SOCIAL INSURANCE AWARD AND TEMPORARY NOTICE OF ELIGIBILITY

An individual who has not yet received his health insurance card may present one of the following to indicate his health insurance entitlement status.

A. Certificate of Social Insurance Award.—Health insurance beneficiaries receive a Certificate of Social Insurance Award (see §399, Exhibit 4) showing the health insurance claim number, dates of entitlement to Part A and Part B, and containing the following statement:

> "This notice may be used if Medicare services are needed before you receive your health insurance card."

B. Temporary Notice of Medicare Eligibility.—When a person 65 years or older needs immediate medical services, the social security office may issue a Temporary Notice of Medicare Eligibility (see §399, Exhibit 5) before a Certificate of Social Insurance Award or health insurance card is issued.

305. IDENTIFYING HEALTH INSURANCE CLAIM NUMBERS

Most HI claim numbers are 9-digit numbers with letter suffixes, e.g., 000-00-000A.

However, it might also be a 6 or 9-digit number with letter prefixes, e.g., A-000000, A-000-00-0000; or WD-000000, WD-000-00-0000. When the status of a beneficiary changes, it is possible for the prefix/suffix of his claim number to change.

A. Health Insurance Claim Numbers.—The potentially valid health insurance claim number is a 9-digit number followed by one of the following:

A, B, B1, B2, B3, B4, B5, B6, B7, B8, B9, BA, BD, BG, BH, BJ, BK, BL, BN, BP, BQ, BR, BT, BW, BY
C1, C2, C3, C4, C5, C6, C7, C8, C9, CA, CB, CC, etc.
D, D1, D2, D3, D4, D5, D6, D7, D8, D9, DA, DC, DD, DG, DH, DJ, DK, DL, DM, DN, DP, DQ, DR, DT, DV, DW, DY
E, E1, E2, E3, E4, E5, E6, E7, E8, E9, EA, EB, EC, ED, EF, EG, EH, EJ, EK, EM
F1, F2, F3, F4, F5, F6, F7, F8
HB, HB1, HB2, HB3, HB4, HB5, HB6, HB9
HC1, HC2, HC3, HC4, HC5, HC6, HC7, HC8, HC9
J1, J2, J3, J4 (See Note 1)
K1, K2, K3, K4, K5, K6, K7, K8, K9, KA, KB, KC, KD, KE, KF, KG, KH, KJ, KL, KM (See Note 1)
W, W1, W2, W3, W4, W5, W6, W7, W8, W9, WB, WC, WF, WG, WJ, WR, WT
M, M1, and T, TA, TB, TC, TD, TE, TF, TG, TH, TJ, TK, TL, TM, TN, TP, TQ, TR, TS, TT, TU, TV, TW, TX, TY, TZ, and T2, T3, T4, T5, T6, T7, T8, T9 (See Note 2)

NOTE NO. 1: Supplementary medical insurance entitlement may exist for all J and K suffixes. However, for subscripts J3, J4, K3, K4, K7, K8, KB, KC, KF, KG, KL, and KM, entitlement to hospital insurance benefits is possible only when the beneficiary is a qualified uninsured individual who secures coverage on a voluntary basis.

NOTE No. 2: Suffix M indicates that the individual is entitled to supplementary medical insurance benefits. The individual may also be entitled to hospital insurance benefits but only as an uninsured individual who has voluntarily secured coverage.

Suffix M1 indicates the individual is entitled to supplementary medical insurance benefits and has refused hospital insurance benefits.

Suffix T indicates the individual is entitled to hospital or hospital and medical insurance and is not entitled to monthly social security benefits.

B. Health Insurance Claim Numbers Assigned by the Railroad Retirement Board (RRB).—The RRB began using the social security number in its numbering system during 1964. The numbers assigned prior to that time are 6-digit numbers; these were assigned in numerical sequence and have no special characteristics. However, both those 6-digit numbers and the 9-digit social security numbers when used as claim numbers by the RRB always have letter prefixes. (In rare cases, a qualified railroad retirement beneficiary may have a claim number with less than 6 digits; sufficient zeros should be added between the prefix and other digits to make a 6-digit number, e.g, WD-001234.)

All-Inclusive List of Potentially Valid RRB Health Insurance Claim Numbers

A-000000, or
A-000-00-0000

MA-000000, or
MA-000-00-0000

WA-000000, or
WA-000-00-0000

WD-000000, or
WD-000-00-0000

CA-000000, or
CA-000-00-0000

WCA-000000, or
WCA-000-00-0000

WCD-000000, or
WCD-000-00-0000

PA-000000, or
PA-000-00-0000

PD-000000, or
PD-000-00-0000

H-000000

MH-000000

WH-000000

WCH-000000

PH-000000

JA-00000

305.1 Changes in Health Insurance Claim Numbers.—Changes in an individual's entitlement to social security or railroad retirement benefits may result in an individual being assigned a completely different HI claim number; e.g., an individual not entitled to monthly benefits (000-00-0000) marries and becomes entitled to wife's benefits on her husband's account (111-11-1111B).

306. NOTICE OF HOSPITAL (OR MEDICAL) INSURANCE UTILIZATION OR EXPLANATION OF BENEFITS

If the patient cannot furnish his health insurance card, or one of the notices described in § 302, he may have a utilization form which shows his claim number. Form HCFA-1533, Medicare Hospital Extended Care and Home Health Benefit Records (see §399, Exhibit 2), is mailed to a beneficiary shortly after Part A, inpatient hospital or extended care benefits have been paid on his behalf. This form is provided only on an "as needed" basis for Part A and Part B home health benefits. Therefore, beneficiaries may or may not have utilization forms for these services. An Explanation of Benefits is sent to a beneficiary by the Part B carrier after payment of a supplementary medical insurance claim. The beneficiary also receives a utilization notice after payment on his behalf for Part B inpatient and outpatient hospital and skilled nursing facility services.

These forms, if current, may indicate to the home health agency the patient's remaining eligibility under hospital or medical insurance, or deductible status prior to July 1, 1981 under supplementary medical insurance.

310. CONTACTS WITH THE SOCIAL SECURITY OFFICE TO OBTAIN HEALTH INSURANCE CLAIM NUMBERS

When a beneficiary cannot furnish his health insurance claim number, an agency may request it from the social security office. Agencies should establish a working procedure with the social security office for obtaining health insurance claim numbers.

If possible, the HHA should obtain a signed statement from the beneficiary authorizing it to file a Medicare claim on his behalf. The signed statement may be one of the following:

1. HCFA-1487, Home Health Agency Report and Billing;
2. HCFA-1483, Provider Billing for Medical and Other Health Services; or
3. A signed request to release a claim number.

Under the Privacy Act, the social security office need not keep a record of the disclosure of the health insurance claim number if the HHA advises that it has this signed statement. Any of the above forms, or the signed request for the release of the claim number, should be retained by the agency for 5 years following the month in which the request was made.

If the agency is unable to obtain the necessary signature, the social security office will still provide the claim number but is required by the Privacy Act to keep a record of the disclosure. Therefore, the agency should obtain the beneficiary's written authorization whenever possible.

NOTE: The social security office will also help a beneficiary replace a lost or destroyed health insurance card.

312. INFORMATION REQUIRED BY THE SOCIAL SECURITY OFFICE

If the patient's social security number is available, the social security office usually requires no additional information to locate the claim number or determine that the patient has not established health insurance entitlement.

If the social security number is not available, the following information should be furnished to the social security office:

A. The patient's name and statement as to whether or not he ever applied for social security monthly benefits, railroad retirement benefits, hospital insurance benefits, or enrolled for supplementary medical insurance;

B. If the patient says he applied, the name of the person on whose social security number the application was based, e.g., his own number or the number of a husband or a wife;

C. The patient's father's full name, mother's maiden name, and the patient's date and place of birth; and

D. Patient's address.

If the home health agency cannot furnish all the above identifying information required from the beneficiary, it should furnish as much as it has to the social security office.

314. THE SOCIAL SECURITY OFFICE REPLY

The social security office will furnish the health insurance claim number as soon as possible. If the claim number is not available, it will inform the home health agency of the action it is taking, i.e., that a claim number has been requested from SSA central records, that it is developing an application, or that an application is pending.

If an application for health insurance benefits is taken as a result of the request to the social security office for a claim number or is pending when the home health agency requests a claim number, the social security office will give the agency the claim number when processing is completed.

322. WHEN THE AGENCY SUBMITS A START OF CARE NOTICE

For services prior to July 1, 1981, a start of care notice is required in the following situations.

A. The patient will receive home health services under Part A after a qualifying stay in a hospital or skilled nursing facility. (Any day paid under waiver of liability is not a qualifying day of stay in an institution.)

B. The patient will receive initial home health services under Part B. This applies when services will be under Part B from the beginning.

C. The patient is discharged from a home health plan of treatment, and the physician later establishes a new plan for services, whether or not it differs from the prior plan.

D. The patient receives home health services from one agency and transfers to another agency.

E. The patient initially received Part B services, and later has a qualifying inpatient stay which entitles him to Part A visits.

F. A patient receiving Part A home health visits has a qualifying stay in a hospital or skilled nursing facility which begins a new spell of illness and entitles him to a new series of 100 Part A visits.

G. The patient's home health visits are suspended for more than 60 days and are resumed thereafter. However, if visits are suspended for more than 60 days but during the 60-day period the physician has reviewed and appropriately recertified the plan, no new start of care notice is required. (See § 441.)

H. Workers' compensation paid or is expected to pay for some home health services but additional home health benefits are payable under Medicare.

323. WHEN THE AGENCY NEED NOT SUBMIT A START OF CARE NOTICE

Generally, a start of care notice is not required for services rendered by an HHA on or subsequent to July 1, 1981, and in the following situations for services rendered prior to July 1, 1981.

A. The home health agency transfers services from Part A to Part B because either visits have been exhausted under Part A or a new spell of illness has begun.

B. Services furnished under Part B extended from one calendar year into another.

C. The same home health agency resumes Part A or Part B home health visits after a temporary suspension for a period no longer than 60 days. (See § 441.)

D. The patient is receiving Part A home health visits, and is readmitted to a hospital or skilled nursing facility in the same spell of illness, and visits continue after discharge from the institution.

E. Workers' compensation has paid or is expected to pay the entire bill.

If you require verification of the patient's eligibility for Medicare benefits prior to rendering services, your intermediary will advise you how to request verification. The intermediary will also advise you how to verify bill routing, if the patient alleges HMO enrollment.

325. HOW THE AGENCY COMPLETES A START OF CARE NOTICE (FORM HCFA-1487), WHEN REQUIRED

All entries should be typed or printed clearly. Show month, day, and when required year in six-digit numbers, e.g., 10-01-80.

ITEM 1. PATIENT'S NAME.

Enter the patient's name as it is shown on his health insurance card. Do not make any changes in the name (except to show the last name first). The SSA master computer record is kept under this name.

ITEM 2. HEALTH INSURANCE CLAIM NUMBER.

Enter the patient's health insurance claim number as shown on his health insurance card, Certificate of Award, Benefits Record, Temporary Notice of Medicare Eligibility, or as reported by the social security office. See Exhibits in § 399.

ITEM 3. PATIENT'S ADDRESS

Enter the patient's mailing address. If the address is an institution, enter the name of the institution.

NOTE: An individual in an institution meeting the basic definition of a hospital or skilled nursing facility cannot be considered to be in a place of residence for purposes of receiving covered home health services; see § 208.5.

ITEM 4. DATE OF BIRTH.

Enter the patient's date of birth. If the year of birth is unknown, make no entry. If the year is known but the month or day is unknown, enter "00" for the missing item, e.g., 00/00/95.

While the date of birth is useful as identification and should be shown when available, a start of care notice will be processed without the date of birth.

ITEM 5. SEX.
Enter "X" in the appropriate box.

ITEMS 6 and 7. HOME HEALTH AGENCY IDENTIFICATION.
Enter the name and address of the agency and the agency's health insurance provider number. This information may be preprinted on all copies of the agency's supply of these forms.

ITEM 8. MEDICAL RECORD NUMBER.
Enter the patient's medical record number if one is assigned by the agency.

ITEM 9. NAME AND ADDRESS OF ATTENDING PHYSICIAN.
Enter the name of the attending physician. The name should be that of the physician who established the plan and will certify and recertify the medical necessity of the home health visits. Show the address only if your intermediary requires this information.

If the plan was set up by an outpatient clinic rather than by a private physician, enter that information. However, if it is known that only one physician or department of the clinic is involved, enter that information.

ITEM 10. DATE CARE STARTED.
Enter the date on which covered home health service actually began. (This cannot be earlier than the patient's effective date of health insurance (Part A or Part B) entitlement.) This date will remain the same on subsequent bills even if (a) the patient transfers from one agency to another or (b) Part B visits will be made because either Part A visits are exhausted or a new spell of illness has begun, but prior stay requirements are not met.

If reimbursable services not charged as visits, e.g., medical supplies and appliances, are furnished before the first visit, Item 10 will be the date these services were first furnished.

ITEM 11. NAME AND ADDRESS OF INSTITUTION, ETC.
If home health visits follow a qualifying inpatient stay, enter the name and address of the hospital or skilled nursing facility.

To qualify for visits under Part A prior to July 1, 1981

A. A spell of illness must have begun (see §§ 112.3 and 210.1).

B. Visits must follow an inpatient hospital stay of at least 3 consecutive days or a covered stay of any duration in a skilled nursing facility (see § 210.2).

Days not covered because the level of care requirements are not met but which fall under the waiver of liability provisions, cannot be used for a qualifying hospital or skilled nursing facility stay.

C. No more than 14 days can pass between discharge from a qualifying stay in a hospital or skilled nursing facility and the establishment of a plan (see § 210.5). However, a plan may be established before the patient is discharged.

In the unusual situation where inpatient stays in two different institutions qualify the patient for Part A visits, i. e., one starts a spell of illness and the other satisfies the prior stay requirement (see § 210.2), the names and addresses of both institutions should be shown in Item 11. If verified, the dates of the stay which began the spell of illness should also be shown in Item 11. See example below.

ITEM 12. VERIFIED DATES OF STAY IN ITEM 11.
Enter the verified dates of the inpatient stay qualifying visits under Part A only when the dates are taken from the official referral sheet of the hospital or skilled nursing facility. Verified dates entered on the initial bill, need not be repeated on subsequent bills.

Days paid under waiver of liability must not be included as a part of the qualifying stay.

Home health agencies may wish to make arrangements with other providers to include the verified dates of stay as part of the normal information furnished when home health visits will follow a qualifying stay.

If inpatient stays in two different institutions qualify the patient for Part A visits (see Item 11 above), the dates of stay that began the spell of illness should be entered in Item 11 and the dates of the qualifying prior stay should be entered in Item 12.

NOTE: Qualifying stays are not a requirement for Part A Home Health services effective July 1, 1981.

ITEM 13. DATE HOME HEALTH PLAN ESTABLISHED.
Show the date on which the patient's attending physician established the plan for home health services.

The date shown in Item 13 can be no later than the "Date Care Started" shown in Item 10.

Home health services may be authorized verbally by a physician. In this case, the date of verbal authorization will be shown. However, for services rendered prior to July 1, 1981 the agency must make sure the plan is reduced to writing within 14 days of discharge from the qualifying stay in a hospital or skilled nursing facility if payments are to be made under Part A. If the services are payable only under Part B, the plan must be reduced to writing before a bill is submitted to the intermediary.

ITEM 14. PAYMENT SOURCE, ETC.
Check the appropriate box to indicate how charges not reimbursed by health insurance will be paid.

If Item E (Public Agency) is checked, enter the name and address of the office to which you look for payment under the public assistance program. The patient's case number should be included, if known.

If any case involving a work-related condition or Federal Employees Hospital Benefits (FEHB), check Item F (Other) and enter the name and address of the carrier as well as the identifying claim number. If an abbreviation is frequently used, enter the full name and address of the organization and put the abbreviation to the right.

If there is no other organization which might pay for some or all of the medical expenses, or the patient or his authorized representative refuses to give that information, or the information is unknown, enter in Item 14 either "none," "Refused," or "Unknown."

NOTE: Refusal to disclose whether workers' compensation will pay for medical expenses could result in a penalty being imposed under §1877(a)(3) of the Social Security Act.

340. RETROACTIVE ENTITLEMENT

When an application for social security benefits is filed by a person 65 years of age or older, he may inform the social security office that he received home health services in the retroactive period of up to 6 months for whch he may be entitled to benefits. Payment for the home health services (Part A only) received in this period is possible. The social security office will tell the individual to get in touch with you. If the patient paid you, refund the appropriate amount.

341. INSTRUCTIONS FOR IDENTIFYING OTHER PRIMARY PAYERS WHEN ESTABLISHING THE HOME HEALTH PLAN OF TREATMENT

Legislation bars Medicare payment under certain circumstances. The following chart is designed to help recognize the circumstances under which Medicare does not pay as primary and to identify the responsible party.

Medicare is not the primary payer:

A. If the items or services have been, or can reasonably be expected to be paid under a workers' compensation law or plan of a State or of the United States including the Federal Black Lung Program. (See §250.);

B. If the items or services have been, or can reasonably be expected to be paid by automobile medical or no-fault insurance, or any liability insurance. (See §§248 and 251.);

C. During a period up to 12 months, if the beneficiary is entitled to benefits solely on the basis of end stage renal disease (ESRD) and is covered by an Employer Group Health Plan (EGHP). (See §252.); or

D. If the beneficiary is age 65 through 69 and employed, or the beneficiary's spouse any age through 69 is employed, and the beneficiary is thereby covered by an EGHP. (See §253.)

The following chart lists questions to ask Medicare beneficiaries when establishing the home health plan of treatment. Use this chart as a guide to help identify other payers listed above which may be primary to Medicare. Before utilizing this chart see §§248, 250, 251, 252, and 253 for further information regarding situations in which Medicare is secondary. Beginning with Part 1, ask the beneficiary each question in sequence. Comply with any instructions which follow an answer you have checked. If the instructions direct you to go to another part, have the beneficiary answer, in sequence, each question under the new part. If an answer you have checked is followed by the message "STOP," bill that beneficiary's services to the insurer indicated.

NOTE: There may be situations where more than one insurer is primary to Medicare (e.g., automobile insurer and EGHP). Be sure to identify all possible insurers.

Part I

1. Was illness/injury due to a work related accident/condition and covered by a workers' compensation plan or the Federal Black Lung Program?

____ yes;

Name and address of workers' compensation plan
or Federal Black Lung Program ____________________

Patient's policy or identification number ________________

STOP: WORKERS' COMPENSATION OR FEDERAL BLACK LUNG PROGRAM IS PRIMARY PAYER.

____ no; GO TO PART II

Part II

1. Was illness/injury due to nonwork related accident?

___ yes.

___ no; GO TO PART III

2. What type of accident caused illness/injury?

___ automobile;

Name and address of automobile insurer ____________________

Insurance claim number ________________

STOP: AUTO INSURER IS PRIMARY PAYER.

___ other;

3. **Was another party responsible for this accident?**

___ yes;

Name and address of any liability insurer ______________________

Insurance claim number ______________________

STOP: LIABILITY INSURER IS PRIMARY PAYER.

___ no; GO TO PART III

Part III

1. Is the patient 70 years of age or older?

___ yes; STOP: MEDICARE IS PRIMARY PAYER.

___ no; GO TO PART IV

Part IV

1. Is the patient aged 65 through 69?

___ yes.

___ no; GO TO PART V

2. Is the patient undergoing kidney dialysis for ESRD?

___ yes; STOP: MEDICARE IS PRIMARY PAYER.

___ no.

3. Is the patient employed and covered by the Employer's Group Health Plan?

___ yes;

Name and address of EGHP ______________________

Patient's identification number ______________________

STOP: EGHP IS PRIMARY PAYER.

___ no;

4. Is the patient's spouse employed and under age 70?

___ yes;

___ no; STOP: MEDICARE IS PRIMARY PAYER.

5. Is the patient covered under the group health plan of the spouse's employer?

___ yes;

Name and address of EGHP ________________________________

Patient's identification number ____________________

STOP: EGHP IS PRIMARY PAYER.

___ no; STOP: MEDICARE IS PRIMARY PAYER.

Part V

1. Is the patient entitled to benefits solely on the basis of End Stage Renal Disease?

___ yes.

___ no; STOP: MEDICARE IS PRIMARY PAYER.

2. Is this patient covered by an Employer Group Health Plan?

___ yes;

Name and address of EGHP ________________________________

Patient's identification number ____________________

___ no; STOP: MEDICARE IS PRIMARY PAYER.

3. Has the patient been undergoing kidney dialysis for more than 12 months or been entitled to Medicare for more than 12 months?

___ yes; STOP: MEDICARE IS PRIMARY PAYER.

___ no;

4. Is the patient within a 12-month period as defined in §252.4?

___ yes; STOP: EGHP IS PRIMARY PAYER.

___ no; STOP: MEDICARE IS PRIMARY PAYER.

399. EXHIBITS

Exhibit 1. Health Insurance Cards.

Exhibit 2. Medicare Hospital Extended Care and Home Health Benefits Record (Form SSA-1533).

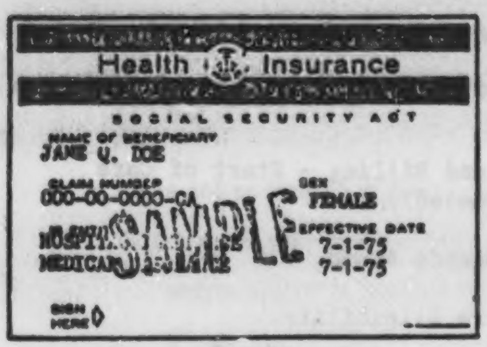
Exhibit 3. Home Helath Agency Report and Billing - Start of Care (Admission Copy) (Form SSA-1487).

Exhibit 4. Certificate of Social Insurance Award.

Exhibit 5. Temporary Notice of Medicare Eligibility.

EXHIBIT 1

HEALTH INSURANCE CARDS



Health Insurance

SOCIAL SECURITY ACT

NAME OF BENEFICIARY
JANE Q. DOE

CLAIM NUMBER
000-00-0000-CA

SEX
FEMALE

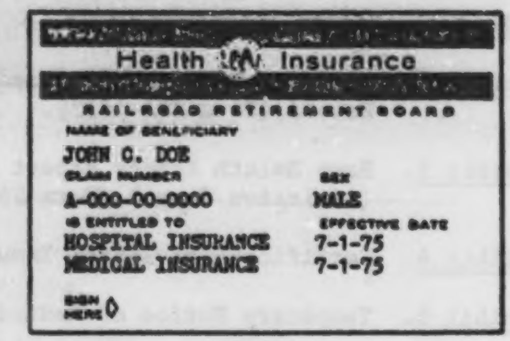
IS ENTITLED TO
HOSPITAL INSURANCE
MEDICAL INSURANCE

EFFECTIVE DATE
7-1-75
7-1-75

SAMPLE

SIGN HERE

Front



Health Insurance

RAILROAD RETIREMENT BOARD

NAME OF BENEFICIARY
JOHN C. DOE

CLAIM NUMBER
A-000-00-0000

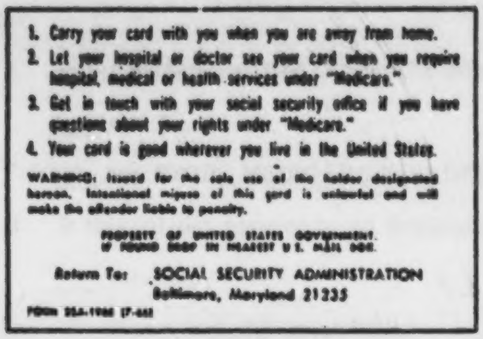
SEX
MALE

IS ENTITLED TO
HOSPITAL INSURANCE
MEDICAL INSURANCE

EFFECTIVE DATE
7-1-75
7-1-75

SIGN HERE

Front



1. Carry your card with you when you are away from home.
2. Let your hospital or doctor see your card when you require hospital, medical or health services under "Medicare."
3. Get in touch with your social security office if you have questions about your rights under "Medicare."
4. Your card is good wherever you live in the United States.

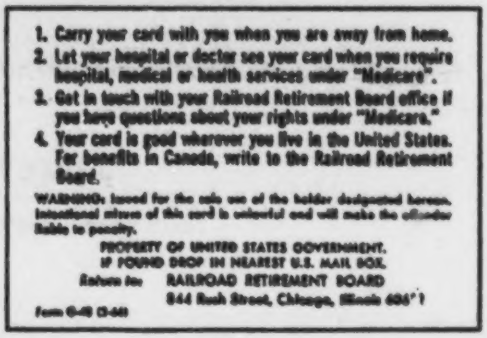
WARNING: Issued for the sole use of the holder designated hereon. Intentional misuse of this card is unlawful and will make the offender liable to penalty.

PROPERTY OF UNITED STATES GOVERNMENT.
IF FOUND DROP IN NEAREST U.S. MAIL BOX.

Return To: SOCIAL SECURITY ADMINISTRATION
Baltimore, Maryland 21235

FORM SSA-1966 (7-66)

Back



1. Carry your card with you when you are away from home.
2. Let your hospital or doctor see your card when you require hospital, medical or health services under "Medicare".
3. Get in touch with your Railroad Retirement Board office if you have questions about your rights under "Medicare."
4. Your card is good wherever you live in the United States. For benefits in Canada, write to the Railroad Retirement Board.

WARNING: Issued for the sole use of the holder designated hereon. Intentional misuse of this card is unlawful and will make the offender liable to penalty.

PROPERTY OF UNITED STATES GOVERNMENT.
IF FOUND DROP IN NEAREST U.S. MAIL BOX.

Return to: RAILROAD RETIREMENT BOARD
844 Rush Street, Chicago, Illinois 60611

Form G-40 (3-66)

Back

Exhibit 2

FORM SSA-1533 (1-73)

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE / SOCIAL SECURITY ADMINISTRATION

MEDICARE HOSPITAL EXTENDED CARE AND HOME HEALTH BENEFITS RECORD

DATE:

HEALTH INSURANCE CLAIM NUMBER

Always use this number when writing about your claim.

THIS IS NOT A BILL. This notice is to give you a record of the Medicare benefits you used during the period shown in Item 1. For important additional information please see the other side of this form.

1 OUR RECORDS SHOW THAT YOU RECEIVED THESE SERVICES

Type of Services	Services Were Provided By	Date

2 MEDICARE HAS PAID FOR ALL COVERED SERVICES EXCEPT

IF YOU HAVE ANY QUESTIONS
ABOUT THIS RECORD
PLEASE GET IN TOUCH WITH:

3 OUR RECORDS SHOW THE FOLLOWING BENEFITS WERE USED THIS TIME

Inpatient Hospital Days	Lifetime Reserve Days	Extended Care Days	Home Health Visits Part A	Home Health Visits Part B

EXHIBIT 2 (Cont.)

EXPLANATION OF ITEMS 1, 2, AND 3

1 PAYMENT OF BENEFITS—Payment for covered services was made on your behalf directly to the organization shown in item 1. Medicare paid for all services covered by the program except for items shown in item 2. YOUR MEDICARE HANDBOOK tells you what hospital insurance pays for in a benefit period and what medical insurance pays for in each calendar year.

Hospital insurance covers inpatient hospital care, skilled nursing facility care and home health agency visits. Home health visits are also covered by Medicare under medical insurance but the 2 benefits are handled separately. The visits you receive under one do not affect the number of visits available under the other. You must be hospitalized for at least 3 days in a row to qualify for home health visits under your hospital insurance but you do not have to be hospitalized first to get home health benefits under your medical insurance.

Generally, Part B medical insurance benefits for services you may have received from a physician or supplier are not included on this record. If you have received Part B physician or supplier services, separate notices about these services will be sent to you.

2 CHARGES NOT PAID BY MEDICARE—Any covered charges not paid for by Medicare are shown in item 2. Medicare does not always pay the full cost of covered services. For example, beginning Jan. 1, 1973 you are responsible for the first $72 in charges for inpatient hospital services in each benefit period. You are responsible for $18 a day for the 61st through 90th day of inpatient hospital services in a benefit period. You are responsible for $9 a day for the 21st through 100th day of inpatient extended care services in a benefit period. You are responsible for $36 a day for each "lifetime reserve" day used. You are responsible for the first $60 of reasonable charges for services covered by Part B in each calendar year.

Physicians' charges are not covered by Medicare hospital insurance, but they are covered by Medicare medical insurance. If you have the medical insurance and received services in a hospital from a radiologist or pathologist (X-ray or laboratory), the reasonable charges for these services are covered in full.

Hospital insurance never pays for some charges, such as TV or telephone and private duty nursing. The added cost of a private room can be paid only if medically necessary. Medical insurance never pays for some charges, such as meals delivered to the home and full time nursing care. YOUR MEDICARE HANDBOOK describes these non-covered items in more detail.

3 BENEFITS USED THIS TIME—Item 3 only shows the number of covered days or visits furnished by the organization and for the period, shown in Item 1. If you received other covered services before or after that date, separate notices about those benefits will be sent to you. A separate notice is sent each time payment for covered services is made on your behalf.

Days or visits still available in the benefit period or in the calendar year will not be paid for unless all Medicare requirements are met. The law does not cover all types and levels of institutional and home care. For a definition of "benefit period" and a detailed explanation of Medicare requirements, see *Your Medicare Handbook* or ask at your social security office.

GENERAL INFORMATION

A. Benefits from Other Insurance or Medical Assistance

If you have other health insurance coverage or qualify for state medical assistance, the insurance organization or state assistance agency may help pay the part of your bill not covered by Medicare. This record may be useful in claiming such benefits.

B. Your Right to Reconsideration of this Medicare Benefit Determination

If you believe that Medicare should have covered more of your expenses, please ask the office shown at the bottom of item 2 for an explanation.

You may also request a reconsideration of the decision. If you want a reconsideration, you must request it not later than 6 months from the date shown on the other side of this record. The request should be sent to your social security office. If you are not satisfied with the reconsideration determination, you may request a hearing. If you want this hearing, you must request it no later than 6 months from the date shown on the notice of reconsideration.

C. For More Information—If you have questions not answered in *Your Medicare Handbook*, please call or visit your social security office. The people there will be glad to help you. If you visit them, be sure to take this record and any other papers concerning the services involved. If you write, be sure to include your Health Insurance Claim Number exactly as it appears on this record.

EXHIBIT 3

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

HOME HEALTH AGENCY REPORT AND BILLING
HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

Form Approved
Budget Bureau No. 72-[illegible]

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law.

1. PATIENT'S LAST NAME | FIRST NAME | MI
2. HEALTH INSURANCE CLAIM NUMBER
3. PATIENT'S ADDRESS (Street number, City, State, ZIP Code)
4. DATE OF BIRTH
5. SEX ☐ M ☐ F
6. HOME HEALTH AGENCY NAME AND ADDRESS
7. PROVIDER NO.
8. NAME AND ADDRESS OF ATTENDING PHYSICIAN
9. MEDICAL RECORD NO.
10. DATE CARE STARTED
11. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES
12. VERIFIED DATES OF STAY IN ITEM 11 FROM TO
13. [illegible]

14. PAYMENT SOURCE FOR CHARGES TO PATIENT
A. ☐ [illegible]
B. ☐ [illegible]
C. ☐ [illegible]
D. ☐ [illegible]
E. ☐ PUBLIC AGENCY (Give name)
F. ☐ Other (Explain)

15. **PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.

SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed) | DATE

16. DIAGNOSES
EMPLOYMENT RELATED A. ☐ YES B. ☐ NO (If yes, give name and address of employer.)

LEAVE BLANK

REPORT OF ELIGIBILITY

A. EFFECTIVE DATE, HOSPITAL INSURANCE
B. EFFECTIVE DATE, MEDICAL INSURANCE
C. DATE OF START OF CARE
D. HOSPITAL INSURANCE VISITS AVAILABLE
E. MEDICAL INSURANCE VISITS AVAILABLE
F. LAST DISCHARGE DATE
G. MEDICAL PLAN DEDUCTIBLE
☐ MET ☐ NOT MET
H. OUTPATIENT PSYCHIATRIC EXPENSE
☐ MET ☐ NOT MET
I. REMARKS:

J. OPEN ITEM
1. INTERMEDIARY
2. PROVIDER
3. ADMITTED
4. DISCHARGED

APPROVED BY | DATE

FORM SSA-1487 (5) (11-[illegible])

ADMISSION COPY

EXHIBIT 4

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

CLAIM NUMBER

Certificate of Social Insurance Award

DATE:

THIS IS TO CERTIFY THAT THE PERSON(S) NAMED BELOW BECAME ENTITLED TO THE INSURANCE BENEFITS SHOWN, PAYABLE UNDER TITLES II AND XVIII OF THE SOCIAL SECURITY ACT.

NAME AND ADDRESS OF PAYEE AS THE CLAIMANT OR AS REPRESENTATIVE OF THE CLAIMANT	TYPE OF BENEFIT	DATE OF ENTITLEMENT	MONTHLY BENEFIT

AMOUNT OF FIRST CHECK:

The right to receive social security benefits carries with it certain responsibilities. They are explained in the booklet furnished you. Read this booklet carefully. Be sure that you understand clearly what you can expect by way of benefits, and what is to be expected of you. If you have any questions or wish additional information about your benefits, please get in touch with any social security office. Most questions can be handled by telephone or mail. If you visit an office, however, please take this Certificate with you.

NOTICE: If you believe that this determination is not correct, you may request that your claim be reconsidered. If you want this reconsideration, you must request it not later than 6 months from the date of this notice. You may make your request through any social security office. If additional evidence is available, you should submit it with your request.

JAMES B. CARDWELL
COMMISSIONER OF SOCIAL SECURITY

FORM SSA-30 [illegible] KEEP AS A PERMANENT RECORD-DO NOT DESTROY

EXHIBIT 5

TEMPORARY NOTICE OF MEDICARE ELIGIBILITY

District Office Address:

Date:

____
Patient's Health Insurance
Claim Number

Dear

Based on the information given to the Social Security Administration, you are (Mr. __________ was) eligible for hospital insurance beginning (mo.) (yr.) and for medical insurance beginning (mo.) (yr.). This notice will serve as evidence of your (his) eligibility for these benefits for 60 days from the date shown at the top of this notice unless you are notified otherwise during the 60-day period.

To obtain medical services (or reimbursement for medical services) before you receive a health insurance card, show this letter to your hospital or doctor but keep the letter with you. This temporary notice of eligibility is to be used only by the person to whom it is addressed. Misuse is unlawful and will make the offender liable to a penalty.

This letter should be destroyed as soon as you receive a health insurance card or other notice of eligibility.

Sincerely yours,

Commissioner of Social Security

IMPORTANT

When services are provided on the basis of this notice, all bills or correspondence with an intermediary or the Social Security Administration should show the patient's health insurance claim number.

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BILLING PROCEDURES

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CHAPTER IV

BILLING PROCEDURES

FOR INTERIM MANUAL INSTRUCTIONS

Section

Billing for DME Furnished As a Home Health Benefit .... IM 414

400. COLLECTION OF DEDUCTIBLE FROM THE PATIENT

There is no deductible for services furnished under a home health plan of treatment. Where billing is for medical and other health services not covered by a plan of treatment, collect the amount of any unmet deductible from the patient. Determine this amount by interviewing the patient. If he/she is unable to conduct his own affairs, interview a member of his family or another interested person.

If you do not know the remaining deductible at the time you bill defer collection from the patient until the intermediary processes your bill, or collect an estimated amount and the intermediary will refund any excess to the patient after processing your bill. HCFA recommends defering collection until the intermediary informs you in the remittance record of the amount of deductible.

In either case, report the amount of deductible collected in the appropriate item of the bill.

401. GENERAL BILLING INFORMATION

Do not put services provided in different accounting periods on the same bill. At the end of the accounting period, submit a bill which contains all services furnished to the patient since the last bill and through the end of the period. Put services furnished in the next accounting period on a separate bill.

The forms used for billing are:

1. HCFA-1450, Inpatient and/or outpatient billing, will be used for all provider billing, except for the professional component of physicians services, beginning no later than September 30, 1985. Where HCFA determines that the form is to be used for Medicare, it replaces the HCFA-1483 and 1487. See §475 for completing Form HCFA-1450.

Specific schedules will be worked out within each State in conjunction with State Uniform Billing Committees, where such exist, or by the HCFA RO and the intermediaries, were such committees do not exist. Providers are responsible for purchasing the forms. This form can be bought as a regular stock item from many printers as a snap-out set or as a continuous pin-feed form (either glued on the side or not). It is available as carbonless or with carbon paper. Medicare accepts any of the above. The standard form set contains five copies, one page of which is designed to bill the patient.

Special orders can be made for fewer copies, e.g. one-part for a Medicare admission notice, four-part excluding patient copy.

2. Until Implementation of Form HCFA-1450, Form HCFA-1487 Home Health Agency Report and Billing, is used to bill for covered home health services. Submit the HCFA-1487 on a periodic basis, e.g., monthly. Always submit a HCFA-1487 when:

a. Visits are to be changed from Part A to Part B;

b. Part B visits and other home health services were rendered, but no benefit is payable because the deductible had not been met. (This applies only to services before July 1981.);

c. The patient (or his representative) refuses to request payment on his behalf. In this case, show "Refused Payment" in the open area under Item 22. (Your intermediary can furnish instructions on how to bill if the patient subsequently decides to request payment.); or

d. When the time limitation on filing for covered services expires before you file a claim for payment, and you are responsible for late filing. (See S236.) (Utilization is charged to the patient even though no Medicare payment is made.)

In addition, your intermediary may require a HCFA-1487 in the following no-payment situations even though no utilization is chargeable: (1) the patient is discharged, (2) the patient dies, (3) visits are exhausted (prior to July 1, 1981), (4) the home health plan is terminated or (5) the beneficiary is responsible for your not filing a timely claim for payment. (See S442.)

3. HCFA-1490S Patient's Request for Medicare Payment.—This form is used only by beneficiaries (or their representatives) who complete and file their own claims.

4. HCFA-1500 Health Insurance Claim Form.—This form was formerly known as the AMA form. It is the prescribed form for claims prepared by physicians or suppliers whether or not the claims are assigned. This form may be obtained from the carrier free-of-charge.

402. BILLING MEDICARE FOR THE PROFESSIONAL COMPONENT OF PROVIDER-BASED PHYSICIAN'S SERVICES

Section 225 defines "provider-based physician," "professional components," and "provider component." The provider component of home health agency based physician's services is reimbursed on a reasonable cost basis.

Part B benefits for the professional component of physician and other nonprovider services are reimbursable on a reasonable charge basis. There are two methods of claiming these benefits: the patient (or his representative) may request payment on the basis of an itemized bill (receipted or unpaid), or he may assign his claim to his source of medical treatment or services. By accepting assignment, the physician (or HHA authorized to bill and receive payment for physician services, see SS428 and 429) can claim the payment. The physician or agency accepting the assignment must agree to consider the reasonable charge determined by the carrier as the full charge for the services.

There are two ways provider-based physician services may be billed:

1. The HCFA-1500, Health Insurance Claim Form. (See §400.2.)

2. The HCFA-1490S, Patient's Request for Medicare Payment. (Used only by the beneficiary to file a claim for physician services.) (See §400.)

The HCFA-1487 is available in the following form sets: (The use of a form set is subject to intermediary approval.)

a. HCFA-1487 (5)—snap-out five-part (3 billing copies, 2 start of care copies)
b. HCFA-1487 (C)—pin-feed three-part (billing copies only)
c. HCFA-1487 (A)—pin-feed two-part (start of care copies only)

3. Also, until implementation of Form HCFA-1450, Form HCFA-1483-Provider Billing for Medical and Other Health Services, is used to bill for certain Part B "medical and other health services" for which you may receive reimbursement. (See §219.)

A start of care notice is not necessary before billing on a HCFA-1483. Upon receipt of the HCFA-1483, the intermediary will determine the beneficiary's Part B deductible status.

404. USE OF CONTINUOUS FEED FORMS BY HOME HEALTH AGENCIES

If the continuous feed versions of billing forms cannot be adapted to your electronic data processing equipment, you may design your own forms. (See §401 for a listing of available form sets.) In such cases, provision may be made for a facsimile signature of the agency's representative on the printed form. Any designed form should follow the format of the standard form, except that variations may be made in spacing, size of margins, length of the form, etc., to make the form compatible with the agency's electronic data processing system. Submit all proposed designed forms through your intermediary for HCFA approval.

To realize the full benefits of an electronic data processing system, the signatures of the beneficiary and provider representatives may be omitted when a mechanical billing technique is employed.

Complete all other items on all forms in accordance with existing instructions.

Accompany each group of bills which do not bear your representatives signature or facsimile signature by a covering letter to the intermediary which includes the following:

> "I certify that required patient signature (or where applicable, appropriate signatures on behalf of patients) and required physician certifications and recertifications are on file, and that the information on the enclosed claims is correct."

412. BILLING FOR SERVICES PROVIDED TO HMO ENROLLEES

Use regular billing forms to bill for HMO enrollees.

In some cases the patient may have enrolled or disenrolled from an HMO plan (according to HCFA records) during the billing period. If the HMO has processing jurisdiction for the HMO involved portion of the bill, the HMO will direct you to split the bill and send the appropriate portions of such bills to your respective components, the intermediary or HMO. When forwarding all bills to the HMO, attach the necessary supporting documents. If the intermediary is responsible for processing the entire bill, it will direct you to split the bill and send both portions to the intermediary.

420. COMPLETING HOME HEALTH AGENCY BILLING FORM HCFA-1487

Examples of completed billing forms are in §450.

NOTE: Home health agencies on the PIP method of reimbursement will also follow the bill completion instructions in this section. Special instructions for agencies on PIP have been included where applicable.

ITEMS 1 THROUGH 14.
Should be completed on the initial billing in the manner described in §325 (start of care notice). However, for services furnished July 1, 1981, or later do not submit a separate start of care notice unless directed to do so by your intermediary.

ITEMS 9, 14, and 15.
May be omitted on interim and final billings. (Item 16 may also be omitted on interim and final bills except for bills falling in the statistical sample. See the explanation for Item 16.) Items 11 and 12 may also be omitted on interim and final billings unless there are later inpatient stays in a hospital or skilled nursing facility (see below).

ITEMS 11 and 12. NAME AND ADDRESSES OF INSTITUTION, ETC., AND VERIFIED DATES, ETC.

A. Services Furnished Prior to July 1981

For services prior to July 1, 1981, the information on inpatient admission and discharge is needed to determine if a new spell of illness has begun or the 1-year period for visits has been extended. See §215.1 for the effect of a later stay on entitlement to Part A home health visits.

Entries in these items do not affect other items on the HCFA-1487 unless they start a new spell of illness. The original "Date Care Started" (Item 10) and "Date Home Health Plan Established" (Item 13) will remain the same. (Items 11 and 12 need not be completed for Part B visits.)

Days not covered because the level of care requirements are not met, but which fall under the waiver of liability provisions, are not used for a qualifying hospital or skilled nursing facility stay.

B. Services furnished on July 1, 1981 or later

Do not complete these items.

ITEM 13. DATE HOME HEALTH PLAN ESTABLISHED
Never make more than one entry on a billing form in this item. If Part A visits are involved, the entry is the date the initial plan was established. The fact the initial plan is amended, or for services prior to July 1, 1981, the patient is reinstitutionalized in the same spell of illness, Part A visits have been exhausted

charge in Item 21K. In the blank space under Item 22, enter "Final Covered Charge." (Note: Newly established HHAs do not submit nonvisit bills because anticipated nonvisit charges have already been included in the average cost per visit interim reimbursement rate.)

Nonvisit charges incurred after termination of a plan must be billed on an HCFA-1483, when reimbursable under Part B.

B. Part B Bills.—HCFA-1487s submitted must include charges for one visit unless one of the following exceptions apply:

1. Part B home health services span 2 calendar years, or
2. The fourth quarter carryover is involved, or
3. The nonvisit charge was incurred after the last home heath visit, but before that plan of treatment terminated. Such bills should be held by the HHA until the plan is terminated and then submitted with the annotation under Item 22, "Final Covered Charge."

If one of the exceptions apply and only nonvisit charges are incurred during the billing period, a HCFA-1487 may be submitted reflecting only nonvisit services.

Nonvisit charges incurred after termination of a plan must be billed on a HCFA-1483, when reimbursable under Part B.

411. SPECIAL BILLING INSTRUCTIONS FOR NEWLY ESTABLISHED HOME HEALTH AGENCIES

Upon submission of a HCFA-1487, newly established home health agencies will be reimbursed on the reasonable average cost per visit method. A newly established home health agency is one for whom a cost report has not yet been submitted for its first year of operation.

When use of durable medical equipment under a plan of treatment coincides with covered home health visits, newly-established home health agencies should not show such equipment as a separate entry in Item 21K, Other. The new HHA should show in Item 21J, only the total number of visits during the period covered by the bill. The anticipated use of such equipment will be included in the average cost per visit interim reimbursement rate calculated for it.

412. BILLING FOR SERVICES PROVIDED TO HMO ENROLLEES

Regular billing forms will be used to bill for HMO enrollees.

In some cases the patient may have enrolled or disenrolled from an HMO plan (according to SSA records) during the billing period. If the HMO has processing jurisdiction for the HMO involved portion of the bill, the HMO will direct the HHA to split the bill and send the appropriate portions of such bills to its respective components, the intermediary or HMO. When forwarding all bills to the HMO, attach the necessary supporting documents. If the intermediary is responsible for processing the entire bill, the intermediary will direct the HHA to split the bill and send both portions to the intermediary.

413. PRESUMED COVERAGE CASE BILL DOCUMENTATION

Presumed coverage provisions may apply to home health services rendered before January 1, 1981. Section 941 of

P.L. 96-466 eliminated this provision for services rendered January 1, 1981, and later.

420. COMPLETING HOME HEALTH AGENCY BILLING FORM HCFA-1487

Examples of completed billing forms are in § 450.

NOTE: Home health agencies on the PIP method of reimbursement will also follow the bill completion instructions in this section. Special instructions for agencies on PIP have been included where applicable.

ITEMS 1 THROUGH 14.

Should be completed on the initial billing in the manner described in § 325 (start of care notice). However, for services furnished July 1, 1981, or later do not submit a separate start of care notice unless directed to do so by your intermediary.

ITEMS 9, 14, and 15.

May be omitted on interim and final billings. (Item 16 may also be omitted on interim and final bills except for bills falling in the statistical sample. See the explanation for Item 16.) Items 11 and 12 may also be omitted on interim and final billings unless there are later inpatient stays in a hospital or skilled nursing facility (see below).

ITEMS 11 and 12. NAME AND ADDRESSES OF INSTITUTION, ETC., AND VERIFIED DATES, ETC.

A. Services Furnished Prior to July 1981

For services prior to July 1, 1981, the information on inpatient admission and discharge is needed to determine if a new spell of illness has begun or the 1-year period for visits has been extended. See § 215.1 for the effect of a later stay on entitlement to Part A home health visits.

Entries in these items do not affect other items on the HCFA-1487 unless they start a new spell of illness. The original "Date Care Started" (Item 10) and "Date Home Health Plan Established" (Item 13) will remain the same. (Items 11 and 12 need not be completed for Part B visits.)

Days not covered because the level of care requirements are not met, but which fall under the waiver of liability provisions, are not used for a qualifying hospital or skilled nursing facility stay.

B. Services furnished on July 1, 1981 or later

Do not complete these items.

ITEM 13. DATE HOME HEALTH PLAN ESTABLISHED

Never make more than one entry on a billing form in this item. If Part A visits are involved, the entry is the date the initial plan was established. The fact the initial plan is amended, or for services prior to July 1, 1981, the patient is reinstitutionalized in the same spell of illness, Part A visits have been exhausted and Part B visits begun, care extends from 1 year into another, etc., is immaterial. The same date could therefore be shown on subsequent bills for a number of years.

ITEM 14. PAYMENT SOURCE FOR CHARGES TO PATIENT
Complete this item if you will bill any source for expenses not reimbursable under Medicare. It may be completed either on the start of care, if completed, or the initial billing. However, do not delay submission of the bill if the information is not available. (See § 325, Item 14, for detailed instruction for completion of this Item.)

ITEM 15. PATIENTS CERTIFICATION AND PAYMENT REQUEST
Have the patient or his authorized representative read the statement on the form or on your record if using the alternate signature procedure (see below). If you obtain the signature on form HCFA-1487, it is sufficient if it is legible only on the original.

A. Signature on Behalf of Patient.—If the patient cannot sign his name because of his physical or mental condition, another person may sign on his behalf, e.g., John J. Jones by Jack A. Smith. (Obtain a brief statement that shows both why the patient did not sign the form and the relationship of the signer.) If the signature is not on form HCFA-1487, the explanation should accompany or be included on the billing form. If the signature is obtained on your own record, include it in your file. In certain situations, a HHA representative may sign on behalf of the patient. (See § 234.4 for who may sign a request for payment.)

Where an illiterate or physically handicapped patient signs by a mark, read the statement to him. A witness signs his name and enters his address next to the mark.

B. Signature on Agency Record.—You may have the patient's signature on your records serve as the request for payment. See § 234.2 for correct language.

Where a beneficiary wants information released to another health insurer or to a State Assistance Agency which is listed by the beneficiary in Item 14 of form HCFA-1487, add the following authorization:

> "I authorize release of information about this claim to those listed in Item 14 of my HCFA-1487, upon their request."

Stamp the original of the billing form or type on the patient's signature line to indicate that the patient's statement is on file. The following wording is suggested:

> "Patient's request for payment in file."

On this basis, the intermediary will make payment without the patient's signature on the billing form until the request for payment is revoked.

ITEM 16. DIAGNOSES

Report ICD-9-CM codes for all the diagnoses shown in the patient's record which relate to the current care. The codes must be the full ICD-9-CM diagnosis codes, including all five digit codes where applicable. List the principal diagnosis code first followed by codes for the first four additional conditions that co-exist. Separate the codes with commas.

Home health visits should relate to the plan of treatment. Enter all diagnoses as furnished by the attending physician. List the principal diagnosis or diagnosis most related to the plan of treatment first.

Enter an "X" in the appropriate box to indicate whether or not the condition is employment related. If the condition is employment related, enter the name and address of the employer on the initial bills. (See § 250-250.2 if workers' compensation is involved.)

ITEM 17. STATEMENT COVERS PERIOD

The "From" date should be the first day of the billing period. On initial bills, the date can be no earlier than the patient's effective date of coverage or the dates in Items 10 and 13 (Date Care Started and Date Home Health Plan Established). If reimbursable home health services not charged as visits are furnished before the first visit, the "From" date must include the date these services were first furnished. Medical supplies or appliances are examples of such services.

On subsequent bills the "From" date must be 1 day later than the "To" date on the previous bill.

The "To" date should be the last day of the billing period. If one of the boxes in Item 19 is checked to show discharged, or visits exhausted (services prior to July 1, 1981), the date that event occurred (Item 20) should be shown as the "To" date.

ITEM 18. DATE OF FIRST AND LAST VISIT

Do not complete.

ITEM 19. PATIENT STATUS

Check only one block to show whether, at the end of the period covered by the bill, the patient is still receiving services, has been discharged, has died, or for services rendered prior to July 1, 1981, that visits have been exhausted.

The "Visits Exhausted" block will be checked only when the patient has exhausted his visits under both Part A and Part B prior to July 1, 1981, and needs additional home health visits. For services July 1, 1981, and after, the 100 visit limitation for Part A and Part B is eliminated and this block should no longer be checked.

In addition to cases in which the patient is discharged because home health services are no longer required, the "discharged" block will be checked in the following situations for services provided prior to July 1, 1981.

a. The patient has exhausted his covered visits and does not need additional visits.

b. The patient is covered only under either Part A or Part B and has exhausted visits covered under that part although noncovered visits will continue.

c. The patient transfers from Part B to Part A.

d. A stay in a hospital or SNF starts a new spell of illness but does not meet the prior stay requirement for visits under Part A and the patient is not entitled to Part B.

e. The patient transfers from one agency to another.

f. The time limit on Part A visits expires but visits are not exhausted. (If visits are to be continued under Part B, "Still Receives Services" is checked, see § 436.)

For services provided July 1, 1981, and later, only item "e" above remains applicable because the visit limitation and the prior stay requirement for Part A have been eliminated.

ITEM 20. DATE APPLICABLE TO ITEM 19.

Enter the appropriate date if Item 19 indicates the patient was discharged or died, or that his visits were exhausted. For services provided July 1, 1981, or after, the visits exhausted block will no longer be checked. The date must be the same as the "to" date in Item 17, except for the situation discussed in § 442. No entry is made when Item 19 indicates the patient is still receiving services.

ITEM 21. STATEMENT OF SERVICES RENDERED.

Payment may not be made for services under Part B if the individual is eligible for payment for those services under Part A. Therefore, billing for services rendered July 1, 1981, and later must always be under Part A where the beneficiary has Part A entitlement. Where the beneficiary is not entitled under Part A, but does have Part B entitlement, billing should be made under Part B. The individual's health insurance card or other notice will indicate whether he has Part A entitlement.

All covered services and items which have been furnished in the billing period must be included in the bill which is being submitted. If workers' compensation paid for some services and Medicare is being billed for others, only the services being billed to Medicare should be shown on the bill.

Home Health services furnished under arrangement with a hospital, SNF, rehabilitation center, supplier, or another home health agency and billed through the home health agency should be shown on the billing form as if the agency furnished the services directly. The HHA will show the services furnished under arrangements on the appropriate line in Item 21 the same way as other services. However, diagnostic services furnished home health patients in the outpatient department of a participating hospital or SNF are not covered home health services and should be billed by the hospital or SNF.

Skilled nursing care provided a patient counts as visits under the guidelines outlined in § 204ff. Physical, speech, and occupational therapy provided by an agency are covered under the guidelines outlined in §§ 203 and 205ff. Other services that may be covered are defined in § 206ff.

Visits to perform noncovered service should not be shown as visits on the billing form. Some examples are services of a domestic or housekeeper unrelated to patient care, "meals on wheels," etc. (See §§ 230 and 232 for additional examples.)

Home health benefits are payable only if an individual needs skilled nursing care or physical or speech therapy. Effective July 1, 1981, benefits are also payable if the individual needs occupational therapy. Effective December 1, 1981, occupational therapy is eliminated as a basis for entitlement to home health services. (See § 203.) For benefits furnished under a Part A or Part B home health plan a form HCFA-1487 should normally be prepared only if such bill includes charges for at least one visit. If only nonvisit charges were incurred during the billing period, the HHA will normally delay submission of the charges and include them on the next billing which shows at least one visit. (See § 410 for exceptions to this rule.)

If the patient does not receive at least one covered skilled nursing or physical or speech therapy visit, or effective July 1, 1981, through November 30, 1981, an occupational therapy visit, (see §§ 203, 204, 205, 206) in a 60-day period, the home health plan is considered terminated unless (1) the physician has reviewed the plan of treatment and made a recertification within the 60-day period which indicates that the lapse of visits is a part of the physician's regimen for the patient (see § 441) or (2) it is clear from the facts in the case that skilled nursing visits will be required at intervals less frequently than once every 60 days, but the intervals are predictable; e.g., it is predictable that services will be required only every 90 days, such as visits for the purpose of changing a silicone catheter. (See §§ 204.1 and 240.1.)

See § 250.3 for situations where part of the home health visits are covered under workers' compensation and part under Medicare due to a limitation under the workers' compensation plan.

Item 21A-G STATEMENT OF SERVICES RENDERED
Should show the total number of visits and the total charges for each type of service listed in items 21 A-G.

If a student nurse performs services under the direct supervision of a licensed nurse, i.e., a licensed nurse accompanies the student nurse to the patient's home, (§ 204.4C) only one visit is charged (§ 218.2) in Item A.

If home health services are furnished on an outpatient basis (see § 206.5), "OP" should be entered by the agency in the space immediately after the name of the particular service; for example: "B. Physical Therapy OP." If outpatient services are reported, this may raise a question as to whether the patient is confined to his home. (See § 208.4 for explanation of home confinement.)

If visits are made by individuals in categories other than those listed in A through F, such as intern, the category should be entered in G, Other Visits, with the number of visits and charges. The services of a male orderly may be covered under the very limited circumstances stated in § 204.4E2.

ITEM 21H-I. TOTAL NUMBER OF UNITS OF SERVICE AND CHARGE PER UNIT OF SERVICE
When an agency bills on the basis of the same charges per unit of service (e.g., visit, week, month), the total number of units is entered in the unshaded area of H. (The number of visits must also be shown in the appropriate category, A through G.)

The agency enters the charge per unit in the unshaded area of I. (However, no charges need be shown in A-G.) No entries should be made by the agency in the shaded areas of H and I. (See § 450, Example I.)

ITEM 21J. TOTALS
The number of visits and charges listed in A through G should be totaled and entered.

ITEM 21K. OTHER
The charges for covered home health services that are not counted as visits should be entered. Each medical appliance and category of supply should be on a separate line with the charge for the item shown on that line. Providers on the average cost per visit (ACV) reimbursement method will not itemize appliances and supplies. (See § 410).

ITEM 21L. TOTAL CHARGES
Contains the sum of charges of lines J and K.

ITEM 21M. AMOUNT PAID BY PATIENT
Not applicable for services after June 30, 1981. The agency should complete this item only on initial Part B billings for services rendered prior to July 1, 1981. The amount actually paid by or on behalf of the patient in the period covered by the bill should be shown. The item relates only to amounts paid toward the Part B deductible for services prior to July 1, 1981. Effective July 1, 1981, the Part B deductible no longer applies. (See § 223).

ITEM 22. POSTHOSPITAL PLAN
Do not complete any of Item 22.

ITEM 23. MEDICAL PLAN
Complete Items A and C through G under this item only for services provided prior to July 1, 1981 that are billed under Part B.

ITEM 23A. VERIFIED DEDUCTIBLE
If the deductible has been met, enter "O" (zero). The amount entered should not exceed $50 for expenses incurred before 1973 and $60 for expenses incurred after 1972. If you do not know the status of the deductible, make no entry.

ITEM 23 B. VERIFIED COINSURANCE
For services furnished after 1972, no entry should be made in this item. (See § 223.2.)

ITEM 23 C. TOTAL CHARGES
The medical plan charges from Item 21L are entered.

This item is not completed for a PIP bill nor for an agency on the average cost per visit method of reimbursement.

ITEM 23 D. REIMBURSEMENT RATE
The figure entered must always be 100 percent or less. It is the relationship of the agency's cost to its charges.

This item is not completed for a PIP bill nor for an agency on the average cost per visit method of reimbursement.

ITEM 23 E. C TIMES D
Enter the total charges (Item 23C) multiplied by the reimbursement rate (Item 23D).

This item is not completed for a PIP bill nor for an agency on the average cost per visit method of reimbursement.

ITEM 23F. E LESS A
Any applicable deductible is subtracted from the amount shown in Item 23E.

This item is not completed for a PIP bill nor for an agency on the average cost per visit method of reimbursement.

ITEM 23G. REIMBURSEMENT AMOUNT 80 PERCENT OF F
For services furnished after 1972, the full amount in Item 23F should be entered (see § 223.2).

ITEM 23H and 23I
These items are for intermediary use. The Home Health Agency should not complete them.

CERTIFICATION, SIGNATURE, AND DATE LINE
An agency representative must certify that the required physician's certification and recertification are on file. A stamped signature is acceptable. The

439. MORE THAN ONE AGENCY FURNISHED HOME HEALTH SERVICES

Wherever possible the following procedures should be used in the exceptional case where a physician deems it necessary to use two participating home health agencies. The physician will designate the agency which will render the major services and assume the major responsibility for the patient's total care as the primary agency. The primary agency will bill for all the services rendered by both agencies to the patient and keep all records pertaining to the care including the plan of treatment, required certifications, and the record of the number of visits. The secondary agency will be reimbursed through the primary agency under mutually agreed upon arrangements.

This procedure assures appropriate coordination of the medical care being received by the patient and provides a means by which each agency furnishing services can be certain when prior to July 1, 1981 the patient's allowable visits are exhausted.

Where agencies do not agree to the above procedure or where a patient is under the care of two physicians, each of whom finds it necessary to establish a home health plan with separate agencies to secure required services, each agency will independently bill for the services it renders. (Note: Each agency must be furnishing its services under a properly established plan of treatment and each must secure independently the necessary physician certifications and recertifications.)

If it comes to the attention of a home health agency that its patient is also receiving services from another agency, each agency should keep the other advised of the visits, etc., furnished by it. This will permit both agencies to keep tract of the services furnished the patient to prevent overutilization.

440. TRANSFER TO ANOTHER AGENCY UNDER THE SAME HOME HEALTH PLAN OF TREATMENT

If a patient transfers from one agency to another and the current home health services are a continuation of the original plan of treatment, the first agency will indicate in Item 19 on its final bill that the patient has been "discharged" and insert in item 20 the date its records are transferred to the other agency.

The second agency will bill as though it was the initial provider under the plan. The bills will continue to show in Item 10 the original date care started by the first agency, etc. On the first bill the second agency submits, the billing period in Item 17 will be from the date of the transfer to the end of the billing period.

441. HOME HEALTH SERVICES ARE SUSPENDED OR TERMINATED THEN REINSTATED

A physician may feel it necessary to suspend visits for a time to determine whether the patient is sufficiently recovered from his condition to do without further home health services. When the suspension is temporary (not more than 60 days) and the physician later determines that the services must be resumed, the resumed services will be paid under the suspension. No special entry is needed on the bill to indicate a suspension. The date care started (item 10) and the date plan established (item 13) will remain the same as on the initial bill. A no-payment bill should not be submitted for the period in which there were no visits.

For purposes of Medicare reimbursement, a suspension of home health visits for more than 60 days terminates the plan of treatment unless the physician has reviewed the plan and made an appropriate recertification (see § 240.1) within 60 days, which would indicate that the lapse of visits is a part of the physician's planned regimen for the patient. If there has been no recertification, a discharge bill is prepared by the agency. To qualify for additional Part A home health visits, prior to July 1, 1981, the patient must have a new qualifying inpatient stay, and a new start of care notice must be submitted. For services provided July 1, 1981, and after the inpatient stay requirement and start of care notice for Part A are eliminated.

There may also be instances in which a physician determines that home health services being furnished under Part A are no longer necessary and discharges the patient. The physician may later determine that the home health services are again necesary and may establish a plan for services related to the same condition for which the individual was previously hospitalized. Since the previous plan of treatment was terminated, for services provided prior to July 1, 1981, the subsequent services cannot be paid under Part A unless the patient has had an intervening qualifying inpatient stay. A new start of care notice would have been submitted if the patient again qualifies for home health visits. For services furnished July 1, 1981 or later the inpatient stay requirement is eliminated, as is the start of care notice requirement when the patient begins receiving home health visits again.

442. PREPARATION OF A HOME HEALTH BILLING FORM IN NO - PAYMENT SITUATIONS

A. No Utilization Chargeable.—Depending on the intermediary's operations it may wish to receive a final no-payment home health billing form when:

1. The patient is discharged.
2. The patient dies.
3. Visits are exhausted. (Effective for services rendered July 1, 1981, and later, benefits can no longer be exhausted).
4. The home health plan is terminated.
5. When the beneficiary is responsible for not filing a timely claim for payment.

In these situations, the date of discharge or death must be later than the "TO DATE" shown in Item 17 on the earlier bill. No-payment bills should always be signed by the home health agency representative.

The information to be entered on the billing form will be limited to identifying information, critical dates, and essential statistical data. The items to be completed will be 1, 2, 4, 5, 7, 10, 17, 19, 20, and 21L.

In situations when a patient already receiving either Part A or Part B home health visits prior to July 1, 1981 has an inpatient stay which begins a new benefit period, see §§ 438 and 450, Example IV.

B. Other Recordable Events.—Even though no Medicare payment is made, a fully completed home health billing form should be submitted when:

1. Part B visits were rendered prior to July 1, 1981, but no benefit is payable because the deductible has not been met. Effective July 1, 1981, the Part B deductible is eliminated for home health services. The Part B deductible still applies to nonvisit charges billed on the HCFA-1483.

2. The patient or his representative refuses to request that payment be made on his behalf. The agency should enter "Refused Payment" in the open area under Item 22 for these bills;

3. The HHA is responsible for not filing a timely claim for payment;

4. When the HHA fails to submit needed information;

5. When the intermediary has notified the HHA that a waiver of liability decision was made that finds the HHA at fault.

443. HOME HEALTH SERVICES UNDER PART B SPANNING TWO CALENDAR YEARS OR THE FOURTH AND A PRIOR QUARTER IN THE SAME CALENDAR YEAR

A. Services Furnished Prior to July 1, 1981

Do not submit a Part B bill for an inclusive period beginning in one calendar year and extending into the following calendar year. If the agency does not normally bill on calendar month basis, it must prepare two bills. The first will cover the period ending December 31 of the old year; the second the period beginning January 1 of the new year. This will permit the intermediary to apply the appropriate deductible for both years. A new start of care notice is not required for the period beginning in the new calendar year.

Similarly, prior to 1981, separate bills were required for a period spanning the last calendar quarter and a preceding quarter where the home health agency records indicated that the deductible was not met in the first three calendar quarters. (See §223.1 for carryover deductible provisions.)

See §401 for the separate billing requirement for services furnished in different accounting periods.

B. Services Furnished July 1, 1981 or Later

There is no Part B deductible applicable to services furnished on July 1, 1981, or later. Therefore, there is no need to separate bills by quarter or year for deductible purposes.

445. PROCEDURES FOR SUBMITTING CORRECTED BILLS

A corrected HCFA-1483 must be submitted if the following apply:

1. A change in provider number;

2. A change in co-insurance on the 1483 involves an amount greater than $1.99.

To correct a previously submitted bill, reproduce a legible copy of the submitted bill. Make corections in red in the appropriate item(s), and mark "CREDIT-DEBIT" in the right-hand margin. If all charges and days reported on the previously submitted bill are to be

deleted, mark it "CANCEL ONLY" in the right-hand margin. Send the corrected bill to the intermediary. On the reverse of the corrected bill, give a brief explanation as to the circumstances that require the correction.

Where there are money adjustments other than co-insurance amount greater than $1.99 record the difference on a record sufficiently documented to establish an accounting data trail, including patient name and HIC Number, first and last dates of services, and any unique numbering or filing code necessary for the HHA to associate the adjustment charge with the original billing. The record must be sufficient to associate with the original bill if necessary.

450. EXAMPLES

NOTE: The Omnibus Reconciliation Act of 1980 eliminates the prior inpatient stay requirement under Part A, the 100 visit limitation under Part A and Part B, and the Part B deductible. Therefore, the following examples pertain to home health services furnished prior to July 1, 1981.

I. Initial Billing--Part A
II. Subsequent Billing--Part A--Less than 3-day Hospital Stay During Billing Period
III. Subsequent Billing--Part A--3-(or more) Day Hospital Stay
IV. Discharge Billing--Part A--New Spell of Illness
V. Initial Billing--Part A--After Transfer from Another Agency
VI. Final Billing--Part A--Services Continue but Part A Visits Exhausted
VII. Initial Billing--Part B--Part A Visits Exhausted
VIII. Subsequent Billing--Part B--Less Than 3-Day Hospital Stay
IX. Final Billing--Part B--Patient Qualifies for Part A
X. Initial Billing--Part A--Appliance Furnished as Home Health Service
XI. Final Billing--Part A--Physician Terminates Plan--Equipment Still Needed
XII. Billing for Rental of Equipment--Part B

EXAMPLE 1

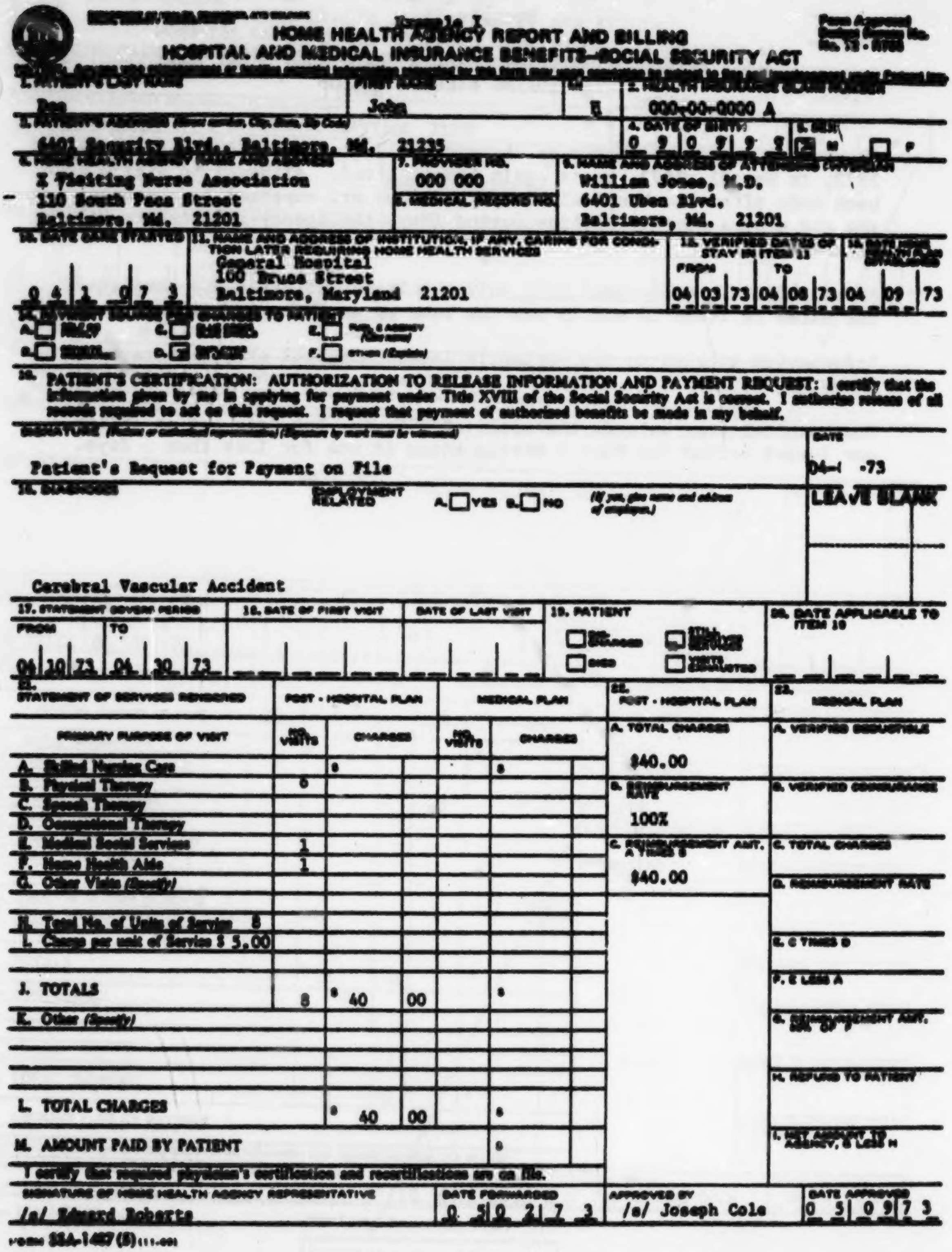
I. INITIAL BILLING—PART A—VISITS

John H. Doe has a qualifying inpatient stay April 3, 1973, through April 8, 1973. A home health plan is established April 9, 1973, and care is started on April 10, 1973.

The home health agency submits a start of care notice. The official transfer records furnished this agency contain the inpatient stay dates and are entered in Item 12. The patient's signature is not required since the agency has obtained it on a form maintained in its own records.

The agency receives a reply which indicates (a) the patient is entitled to Part A and Part B, (b) he has 100 visits remaining under both plans, (c) the Part B deductible is met.

The agency charges a unit rate of $5.00 a visit and the agree-upon reimbursement rate is 100 percent. Since the agency has a uniform rate for all services, no charges are entered in Items 21A through 21G.



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Example I

Form Approved
Budget Bureau No.
No. [illegible]

HOME HEALTH AGENCY REPORT AND BILLING
HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

[illegible]

1. PATIENT'S LAST NAME: Doe
FIRST NAME: John
MI: H
2. HEALTH INSURANCE CLAIM NUMBER: 000-00-0000 A
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code): 6401 Security Blvd., Baltimore, Md. 21235
4. DATE OF BIRTH: 0 9 | 0 9 | 9 9
5. SEX: ☒ M ☐ F
6. HOME HEALTH AGENCY NAME AND ADDRESS:
X Visiting Nurse Association
110 South Paca Street
Baltimore, Md. 21201
7. PROVIDER NO.: 000 000
8. MEDICAL RECORD NO.:
9. NAME AND ADDRESS OF ATTENDING PHYSICIAN:
William Jones, M.D.
6401 Uben Blvd.
Baltimore, Md. 21201
10. DATE CARE STARTED: 0 4 | 1 0 | 7 3
11. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES:
General Hospital
100 Bruce Street
Baltimore, Maryland 21201
12. VERIFIED DATES OF STAY IN ITEM 11: FROM 04 | 03 | 73 TO 04 | 08 | 73
13. [illegible]: 04 | 09 | 73
14. [illegible] CHARGES TO PATIENT:
A. ☐ [illegible] C. ☐ BLUE CROSS E. ☐ PUBL. AGENCY (Give name)
B. ☐ [illegible] D. ☒ [illegible] F. ☐ OTHER (Explain)

15. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.

SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed): Patient's Request for Payment on File
DATE: 04-(-73

16. DIAGNOSIS: Cerebral Vascular Accident
EMPLOYMENT RELATED A. ☐ YES B. ☐ NO (If yes, give name and address of employer.)

LEAVE BLANK

17. STATEMENT COVERS PERIOD FROM 04 | 10 | 73 TO 04 | 30 | 73
18. DATE OF FIRST VISIT:
DATE OF LAST VISIT:
19. PATIENT: ☐ DISCHARGED ☒ STILL RECEIVING SERVICES ☐ DIED ☐ VISITS DISCONTINUED
20. DATE APPLICABLE TO ITEM 19:

21. STATEMENT OF SERVICES RENDERED

PRIMARY PURPOSE OF VISIT	POST - HOSPITAL PLAN NO. VISITS	POST - HOSPITAL PLAN CHARGES		MEDICAL PLAN NO. VISITS	MEDICAL PLAN CHARGES	
A. Skilled Nursing Care		$			$	
B. Physical Therapy	6					
C. Speech Therapy						
D. Occupational Therapy						
E. Medical Social Services	1					
F. Home Health Aide	1					
G. Other Visits (Specify)						
H. Total No. of Units of Service 8						
I. Charge per unit of Service $ 5.00						
J. TOTALS	8	$ 40	00		$	
K. Other (Specify)						
L. TOTAL CHARGES		$ 40	00		$	
M. AMOUNT PAID BY PATIENT					$	

22. POST - HOSPITAL PLAN
A. TOTAL CHARGES: $40.00
B. REIMBURSEMENT RATE: 100%
C. REIMBURSEMENT AMT. A TIMES B: $40.00

23. MEDICAL PLAN
A. VERIFIED DEDUCTIBLE
B. VERIFIED COINSURANCE
C. TOTAL CHARGES
D. REIMBURSEMENT RATE
E. C TIMES D
F. E LESS A
G. REIMBURSEMENT AMT. [illegible] OF F
H. REFUND TO PATIENT
I. NET AMOUNT TO AGENCY, G LESS H

I certify that required physician's certification and recertifications are on file.

SIGNATURE OF HOME HEALTH AGENCY REPRESENTATIVE: /s/ Edward Roberts
DATE FORWARDED: 0 5 | 0 2 | 7 3
APPROVED BY: /s/ Joseph Cole
DATE APPROVED: 0 5 | 0 9 | 7 3

FORM SSA-1487 (5) (11-69)

Example II

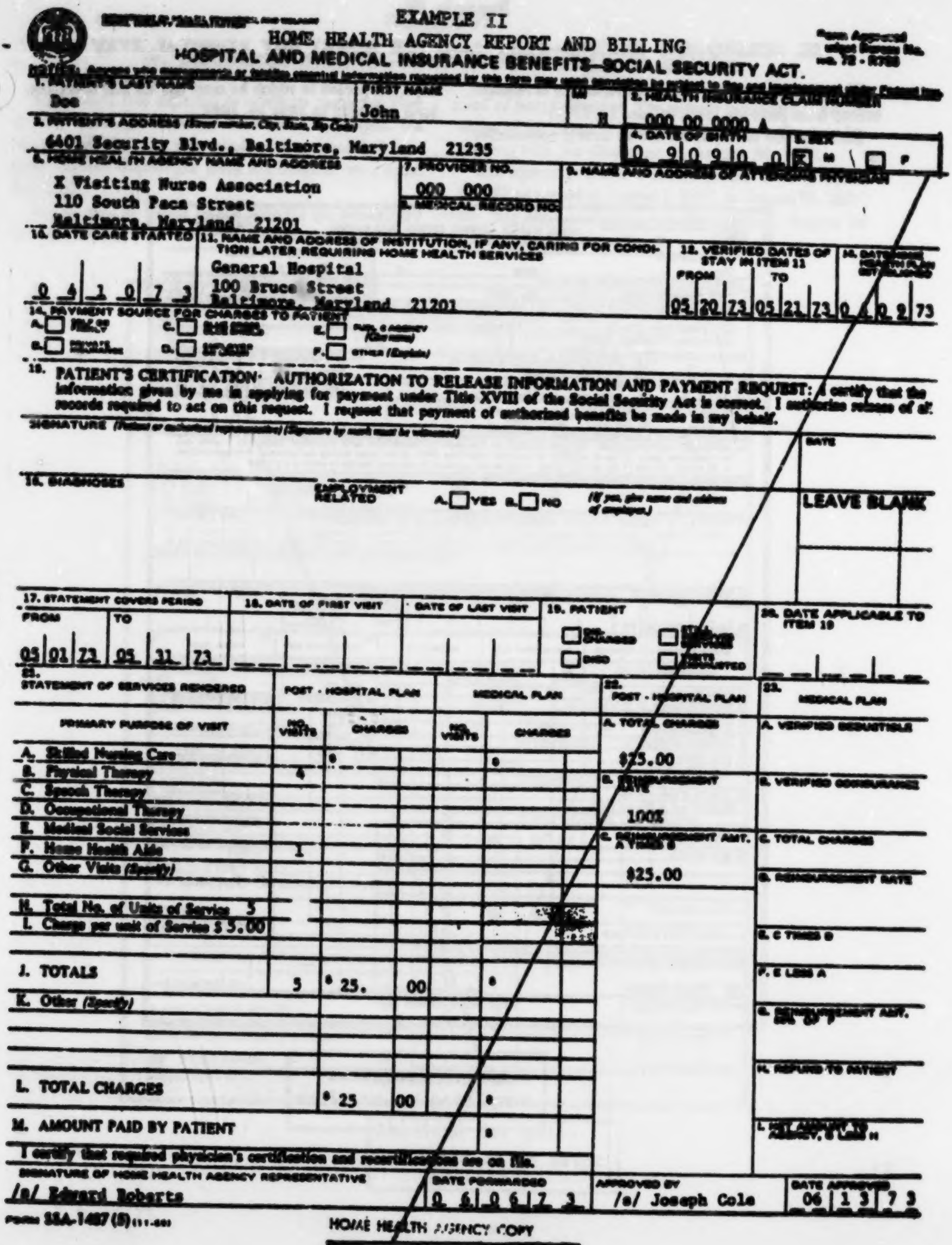
II. SUBSEQUENT BILLING—PART A—LESS THAN 3-DAY HOSPITAL STAY DURING BILLING PERIOD

The agency continues visits to the patient during May. However, on May 20, 1973, to May 21, 1973, he is again hospitalized. Although no visits have been made after the hospital discharge, they are expected to continue. At the end of the monthly billing period (May) the agency submits its billing as indicated.

Since this is a subsequent bill only the items indicated are completed. The dates in Items 10 and 13 are the same as on the prior bill.

Information related to the patient's latest hospital stay is entered in Items 11 and 12.

The hospital stay extends the spell of illness, but does not establish a new 1-year period for Part A visits since it was for less than 3 days.



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

EXAMPLE II

HOME HEALTH AGENCY REPORT AND BILLING

HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT.

Form Approved
Budget Bureau No.
72-R[illegible]

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law.

1. PATIENT'S LAST NAME: Doe
FIRST NAME: John
MI: H
2. HEALTH INSURANCE CLAIM NUMBER: 000 00 0000 A
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code): 6401 Security Blvd., Baltimore, Maryland 21235
4. DATE OF BIRTH: 0 9 | 0 9 | 0 0
5. SEX: ☒ M ☐ F
6. HOME HEALTH AGENCY NAME AND ADDRESS:
X Visiting Nurse Association
110 South Paca Street
Baltimore, Maryland 21201
7. PROVIDER NO.: 000 000
8. MEDICAL RECORD NO.:
9. NAME AND ADDRESS OF ATTENDING PHYSICIAN:
10. DATE CARE STARTED: 0 4 | 1 0 | 7 3
11. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES:
General Hospital
100 Bruce Street
Baltimore, Maryland 21201
12. VERIFIED DATES OF STAY IN ITEM 11: FROM 05 | 20 | 73 TO 05 | 21 | 73
13. DATE HOME HEALTH PLAN ESTABLISHED: 0 4 | 0 9 | 73
14. PAYMENT SOURCE FOR CHARGES TO PATIENT
A. ☐ SELF OR FAMILY
B. ☐ PRIVATE INSURANCE
C. ☐ BLUE CROSS, BLUE SHIELD
D. ☐ EMPLOYER OR UNION
E. ☐ PUBLIC AGENCY (Give name)
F. ☐ OTHER (Explain)

15. PATIENT'S CERTIFICATION· AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.

SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)
DATE

16. DIAGNOSES
EMPLOYMENT RELATED A. ☐ YES B. ☐ NO (If yes, give name and address of employer.)
LEAVE BLANK

17. STATEMENT COVERS PERIOD: FROM 05 | 01 | 73 TO 05 | 31 | 73
18. DATE OF FIRST VISIT:
DATE OF LAST VISIT:
19. PATIENT: ☐ DISCHARGED ☐ DIED ☐ STILL RECEIVING SERVICES ☐ VISITS EXHAUSTED
20. DATE APPLICABLE TO ITEM 19:

21. STATEMENT OF SERVICES RENDERED	POST - HOSPITAL PLAN			MEDICAL PLAN		
PRIMARY PURPOSE OF VISIT	NO. VISITS	CHARGES		NO. VISITS	CHARGES	
A. Skilled Nursing Care		$			$	
B. Physical Therapy	4					
C. Speech Therapy						
D. Occupational Therapy						
E. Medical Social Services						
F. Home Health Aide	1					
G. Other Visits (Specify)						
H. Total No. of Units of Service 5						
I. Charge per unit of Service $ 5.00						
J. TOTALS	5	$ 25.	00		$	
K. Other (Specify)						
L. TOTAL CHARGES		$ 25	00		$	
M. AMOUNT PAID BY PATIENT					$	

22. POST - HOSPITAL PLAN	23. MEDICAL PLAN
A. TOTAL CHARGES $25.00	A. VERIFIED DEDUCTIBLE
B. REIMBURSEMENT RATE 100%	B. VERIFIED COINSURANCE
C. REIMBURSEMENT AMT. A TIMES B $25.00	C. TOTAL CHARGES
	D. REIMBURSEMENT RATE
	E. C TIMES D
	F. E LESS A
	G. REIMBURSEMENT AMT. 80% OF F
	H. REFUND TO PATIENT
	I. NET AMOUNT TO AGENCY, G LESS H

I certify that required physician's certification and recertifications are on file.

SIGNATURE OF HOME HEALTH AGENCY REPRESENTATIVE: /s/ Edward Roberts
DATE FORWARDED: 0 6 | 0 6 | 7 3
APPROVED BY: /s/ Joseph Cole
DATE APPROVED: 06 | 1 3 | 7 3

Form SSA-1487 (5) (11-66)

HOME HEALTH AGENCY COPY

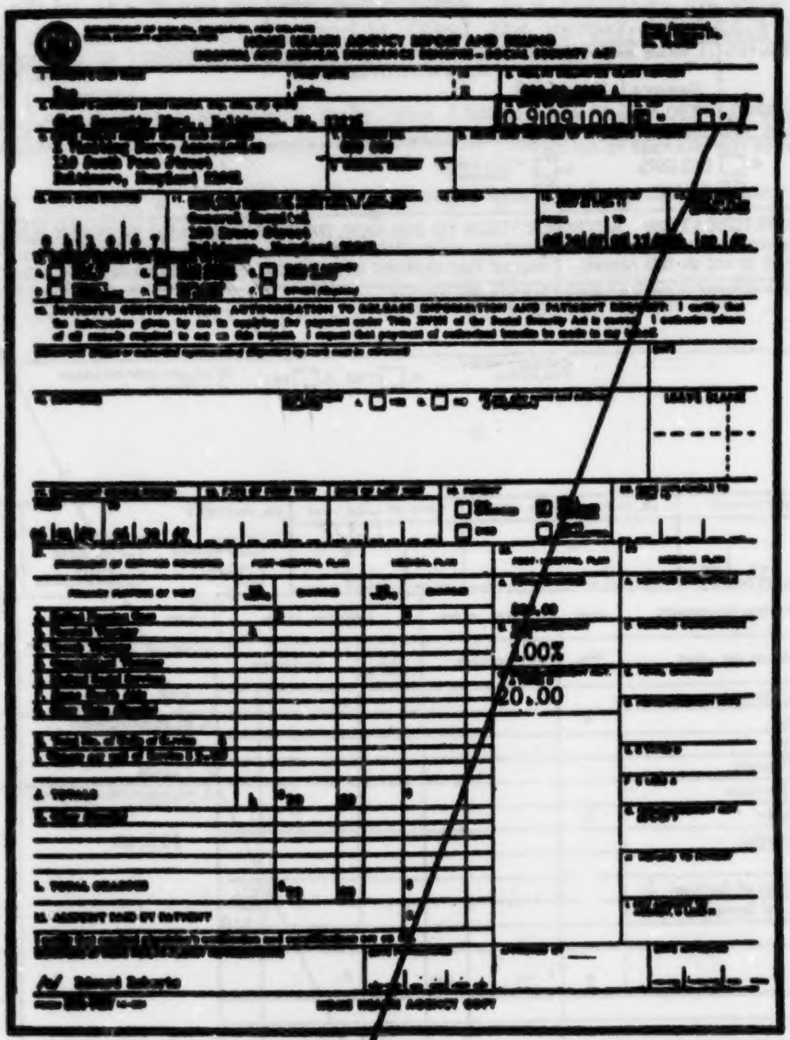
Required for bills
completed on or after
11/1/75.

Example III

III. SUBSEQUENT BILLING—PART A—3 (OR MORE) DAY HOSPITAL STAY

The patient continues to receive visits. He is rehospitalized from June 10, 1967, to June 17, 1967.

Since he was an inpatient for at least 3 consecutive days, the period in which he must use his 100 visits has been extended to June 16, 1968.



Required for bills completed on or after 11/1/75.

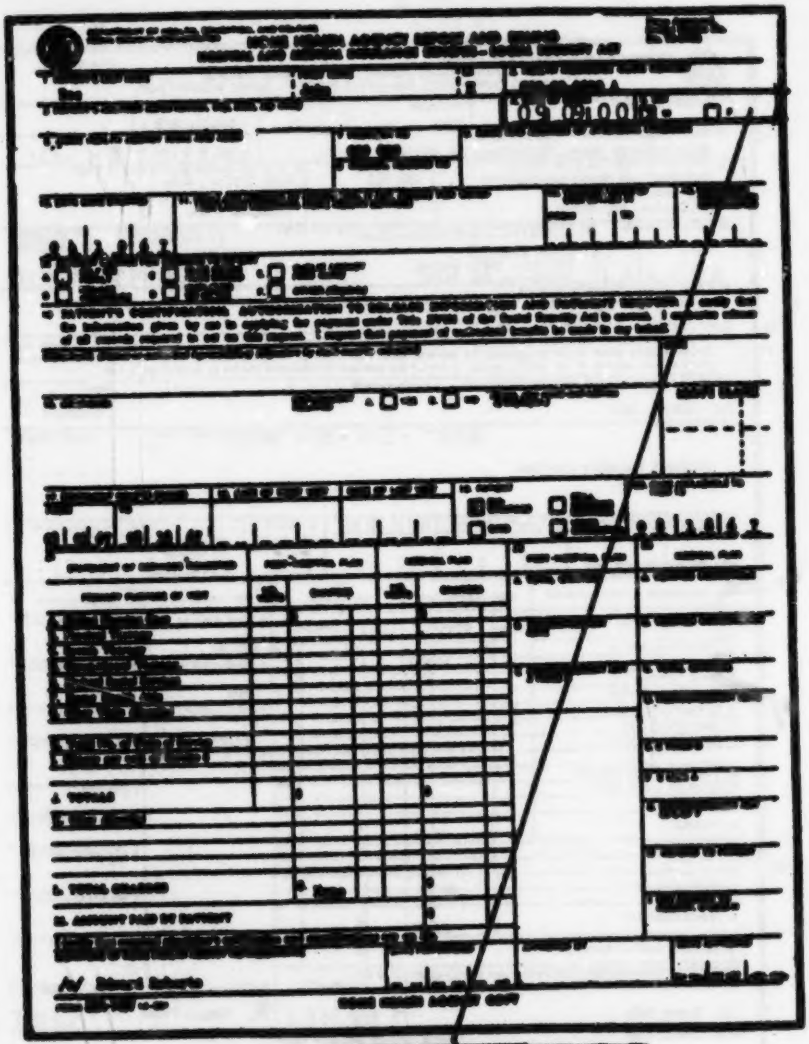
Example IV

IV. DISCHARGE BILLING—PART A—NEW SPELL OF ILLNESS

The patient was expected to continue receiving Part A visits although none had been made in August. On August 18, 1967, he was admitted to a qualified hospital. He was discharged from the hospital on August 24, 1967.

A new spell of illness begins because the beneficiary was not an inpatient in the 60 days preceding this period of hospitalization. The patient is entitled to a new series of 100 Part A home health visits in the year beginning with his discharge on August 24, 1967.

The agency prepares a discharge bill. Item 17 shows the billing period as August 1, 1967, to August 18, 1967, the date the beneficiary was hospitalized. August 18 is also shown in Item 20.



Required for bills completed on or after 11/1/75.

Example V

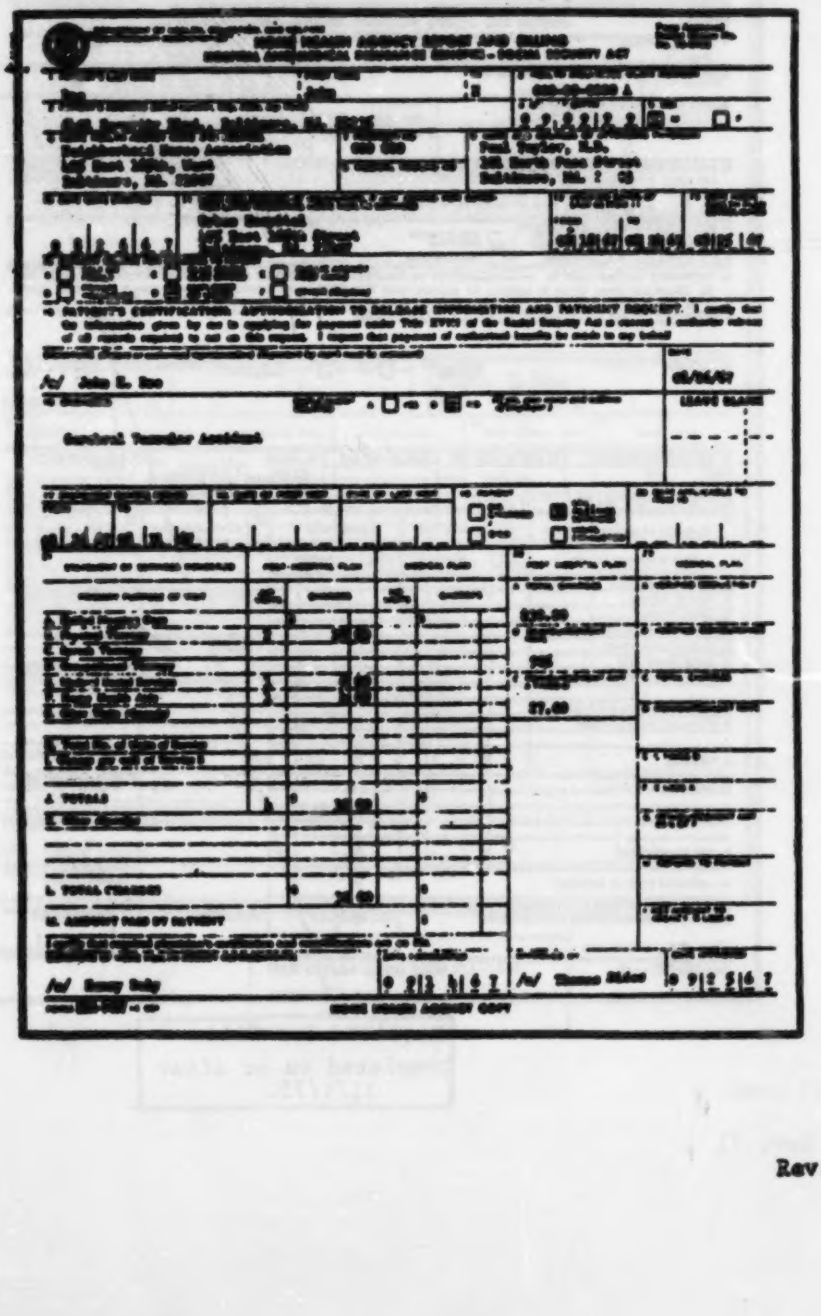
V. INITIAL BILLING—PART A—AFTER TRANSFER FROM ANOTHER AGENCY

On the basis of Mr. Doe's qualifying inpatient stay, August 18, 1967, to August 24, 1967, a new home health plan was established. Visits will now be made by another home health agency.

A new start of care notice shows the plan was established August 25, 1967, and the care started August 26, 1967. The official transfer records furnished this home health agency contain the inpatient stay dates and are therefore entered in Item 12. The home health agency has the patient sign the SSA-1487.

The home health agency charges on a visit basis but has different rates according to the type of visit. The agreed-upon reimbursement rate is 90%.

On September 14 the agency submits the billing shown below.



representative should sign the form before it is submitted to the intermediary. The date forwarded block should be left blank.

421. COMPLETING FORM HCFA-1487 FOR HMO ENROLLEES

The regular instructions for completing the HCFA-1487 apply to HMO involved claims with the following modifications.

ITEM 14. PAYMENT SOURCE FOR CHARGES TO PATIENT

Check box F and enter the name and address of the HMO and the beneficiary HMO enrollment number.

In the blank space under Item 22C, enter "Remarks" and "HMO Enrollee."

See § 422 for disposition of the bill.

422. DISPOSITION OF FORM HCFA-1487

Retain the copy designated "Home Health Agency Copy" and submit the remaining copies to your intermediary, HMO, or HCFA in direct dealing situations. Where you know that the bill will be paid by the HMO, send it and any necessary supporting documentation directly to the HMO for coverage determination, payment, and/or denial action. Bills that you know will be paid and processed by the intermediary and bills where you don't know who has jurisdiction, send directly to the intermediary, in an envelope specially marked "HMO Bills," containing only HMO bills.

424. HCFA-1554, PROVIDER BILLING FOR PATIENT SERVICES BY PHYSICIANS

This form is submitted to the Part B carrier to obtain compensation related reimbursement if:

A. The HHA is entitled to bill for and receive payment for physician's services separately from the charges for provider services, and is not in the process of establishing customary charges for the services.

See § 470ff. for detailed instructions on completion of the HCFA-1554.

For beneficiaries who are HMO enrollees complete and route the bill in accordance with regular billing procedures. No special documentation is necessary, even where the bill will be processed by an HMO.

425. USE OF HCFA-1490 OR HCFA-1500

The HCFA-1490, Request for Medicare Payment or HCFA-1500, Health Insurance Claim Form are submitted to the Part B carrier in the following situations:

A. Where the physician accepts assignment and bills Medicare in his own name; or

B. Where the physician bills the beneficiary and completes the physician or supplier information section of the claim form;or

C. Where the Home Health Agency:

1. Is entitled to bill and receive payment for physician services; and
2. Customarily identifies charges for all the physician's professional services separately from charges for provider services or is in the process of establishing customary charges for such services; and

3. Either:

a. accepts an assignment and bills Medicare for the physician services; or

b. bills the beneficiary for the physician services and completes the physician or supplier information section of the claim form.

The carrier will advise you which form to use.

426. COMPLETION OF THE HCFA-1490 OR HCFA-1500

A. HCFA-1490.--Instructions for completion of the HCFA-1490 are on the back of the form. However, the following special instructions apply where a Home Health Agency is entitled to bill and receive payment for physician services.

1. Item 7A - Date of Each Service.--Show the date of each service. If the same services are furnished on different dates, show each date. If the services are identical, inclusive dates may be used, but the number of times the identical services were furnished must be shown in item 7C.

2. Item 7B - Place of Service.--Enter the place of service codes from the footnote at the bottom of the form.

3. Item 7C - Description of Services and Supplies.--Describe each procedure or enter the appropriate procedure code. If a code is entered, use the code approved by the HCFA carrier for the procedure. Services furnished by different physicians to the same patient may be billed on a single claim. However, each physician must be identified by name and identification code.

4. Item 7D - Nature of the Illness or Injury.--Enter one of the following: (1) nature of illness, injury, symptom or complaint; (2) diagnostic code acceptable to the carrier; or (3) name of referring physician.

5. Item 7E - Charges.--Enter the itemized charge for each procedure or service.

6. Item 8 - Name and Address of Physician or Supplier.--Enter the name and address of the home health agency.

7. Item 9 - Total Charges.--Enter the total charge.

8. Item 10 - Amount Paid.--Enter amount paid by patient. If nothing was paid, enter zero.

9. Item 11 - Any Unpaid Balance Due.--Enter the difference between items 9 and 10. If item 10 is zero, enter amount from item 9.

10. Item 12 - Assignment of Patient's Bill.--If assignment is taken, check appropriate block.

11. Item 14 - Signature of Physician or Supplier.--Signature of authorized official. This official need not be a physician and a stamp facsimile may be used.

For beneficiaries who are HMO enrollees, complete and route the bill in accordance with regular billing procedures. No special documentation is necessary, even where the bill will be processed by an HMO.

B. HCFA-1500.—Items 1-13 Patient Identification Information.—

Item 1 - Enter the patient's first name, middle initial, if any, and last name from his Medicare card.

Item 2 - Enter the patient's date of birth if known.

Item 3 - Not required for Medicare.

Item 4 - Enter the patient's complete mailing address, i.e., number, streeet, city, State, and zip code. Also, enter the telephone number if available.

Item 5 - Check the correct sex designation.

Item 6 - Enter the complete health insurance claim number along with a Medicaid number if appropriate.

Item 7 - Not required for Medicare.

Item 8 - Enter the name of the patient's health maintenance organization if applicable.

Item 9 - If the patient has other health insurance besides Medicare (e.g., private supplementary insurance, Medicaid, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), this item should contain the name of the insuring organization, the policy or medical assistance number, and unless self-evident, whether the coverage is under a Federal program.

Item 10 - A. This item must be completed to show whether the patient's condition is employment related.

B. If an auto accident is involved, check the box for "auto."

Item 11 - Not required for Medicare.

Item 12 - The patient or his authorized representative must sign in this block. If the patient's representative signs, the relationship of the representative to the patient should be indicated. The patient's signature authorizes release of medical information necessary to process the claim. The beneficiary's signature also authorizes payment of benefits to the physician, if the physician agrees to accept assignment in Item 26.

Signature by Mark.—Where an illiterate or physically handicapped enrollee signs by mark (X), a witness should sign his name and enter his address next to the mark.

Item 13 - Not required for Medicare.

Items 14 through 18 - not required for Medicare

Item 19 - If the patient was referred to you enter the complete name of the referring source in this block. Otherwise the item is left blank.

Item 20 - Enter the admission and discharge dates when the service was rendered as a result of or subsequent to a related hospitalization.

Item 21 - Enter place where the service was done.

Item 22 - This item is intended for physicians who are billing for lab services obtained elsewhere. Home health agencies need not complete it.

Item 23 - Enter the nature of injury and/or all relevant diagnoses. A diagnosis code from the ICD-9-CM coding system may be shown in lieu of a narrative description. When more than one diagnosis is indicated on the claim form, in Column D of Item 24 each diagnosis (using reference number; i.e., 1, 2, 3, 4, or DX code) should be related to the appropriate procedure listed in Item 24. If a procedure relates to more than one diagnosis, the primary diagnosis to which the procedure relates should be the one referred to in Column D of Item 24.

Item 24 - In Column A enter the month, day and year for each consultation or procedure.

If "from" and "to" dates are shown here for a series of identical services enter the number of those services in Column F.

In Column B, enter only the applicable Alpha Codes shown in parentheses on the back of the form except (RTC) and (STF).

In Column C, there is space for a written description of procedures and services performed as well as a column where procedure codes may be listed. If a physician/supplier enters codes in Item 24C, the System of Codes must be identified and be agreed to by the carrier. For anesthesia, the elapsed time (hours/minutes) should be shown.

In Column D, enter the diagnosis reference number (i.e., 1, 2, 3, or the diagnosis code) as shown in Item 23, to relate the date of service and the procedures performed to the appropriate diagnosis.

In Column E, enter the charge for each listed service. A description of any unusual circumstances in Column C will help avoid claims processing delays related to unusual charges.

In Column F, enter the number of times a service was performed if "to" and "form" dates were entered in column A

Leave Column G blank.
Leave Column H blank.

Item 25 - The Home Health Agency representative must sign in Item 25. Month, day, and year the form was signed must also be provided. A stamp facsimile signature may be used.

Item 26 - This item must be completed to indicate the Home Health Agency accepts assignment.

Items 27, 28, 29 - Self-explanatory. These items must be completed in all cases. If nothing has been paid on the bill, "None" should be entered in Item 28.

Item 30, 31, 33 - Enter the Home Health Agency's employer identification number in item 30 or 33. Enter in item 31 the identification number assigned by the carrier for claims from this physician.

Item 32 - Your identification number for the patient in case of a request for additional information.

427. LIMITATIONS ON REASSIGNMENT

Assigned benefits for services reimbursable on a reasonable charge basis may not be paid to anyone other than the physician who furnished the services for which the benefits are paid, except:

A. To the employer of the physician who provided the service, if such physician is required as a condition of his employment to turn over his fee for the service to his employer (see S 428); or

B. To a facility in which the service is provided if there is a contractual arrangement between the facility and the physician furnishing the service under which only the facility can bill for the service; or

C. To a foundation, plan, or similar organization which furnishes health care through an organized health care delivery system (e.g., a free-standing physician clinic, or prepaid group practice prepayment plan) if there is a contractual arrangement between the organization and the physician furnishing the service under which only the organization can bill for the service.

428. PAYMENT TO EMPLOYER OF PHYSICIAN

A. General.—Subject to certain conditions and limitations described below, payment of Part B benefits due a physician under assignment for services furnished to a patient may be made to the physician's employer provided that only the employer and not the physician has the right to receive the fees for the physician's services under the terms of the physician's employment. There must be an employer-employee relationship between the physician and the person or organization hiring him to perform services and the terms of the employment must provide that the employer and not the physician has the right to receive the payment for all the latter's services within the scope of his employment. Where the employer has the right, as a condition of employment, to fees for all professional services the physician renders, including those outside the scope of the employment, a reassignment of benefits for all such services will be honored.

B. Information Necessary to Permit Payment to an Employer.—Ordinarily, an employer may establish that it qualifies to receive payment for the services of its physicians by submitting a written statement certifying that it will bill the program for such services only where the physicians are its employees and have acknowledged in writing its right to receive the fees under the terms of their employment. (If it is a governmental entity, the employer's affirmation that it has the right to the fees under law or regulation will substitute for its certification that it has the written acknowledgment of the physicians as to that right.)

The physician's written acknowledgement that the employer has the right to receive payment for his services may be in the form of a written employment contract which either expressly or by clear implication provides that the employer will receive the fees. In the absence of such a contract, the employer should have in its possession a signed and dated statement by the physician acknowledging that the employer has the right under the terms of the employment to receive the payment for the physician's services. The following language is recommended:

> I acknowledge that under the terms of my employment only (Name of Employer) is entitled to claim or receive any fees or charges for my services.

However, any authorization of the kind already obtained from the physician under the pre-amendment instructions will suffice as the physician's acknowledgment. The pre-amendment instructions recommended language such as the following:

> I hereby authorize the (Name of Employer) or any of its duly authorized administrators to accept on my behalf any assignment made by any

individual who receives medical treatment from me at (Name of Institution) of the amount payable to such individual under Part B of title XVIII of the Social Security Act and to receive on my behalf any payments which may be made pursuant to such assignment. It is understood and agreed that the reasonable charge which will serve as the basis for payment in accordance with the terms of such assignment shall be the full charge for the service.

429. ESTABLISHING THAT A HOME HEALTH AGENCY QUALIFIES TO RECEIVE PART B PAYMENT ON THE BASIS OF REASSIGNMENT

An HHA wishing to receive Part B payment as a reassignee of one or more physicians must furnish the Part B carrier sufficient information to receive payment for their services. Where there is any doubt that an HHA qualifies as a reassignee, the Part B carrier will obtain additional evidence.

Where an HHA qualifies as a reassignee, it assumes the same liability for any overpayment which it may receive as a reassignee as the physician would have had if the payment had been made to him.

431. SCOPE OF WAIVER OF LIABILITY PROVISION

Services provided by a home health agency may be covered under a Part A home health plan, or Part B home health plan, or where there is no acceptable plan they may be covered (and billed on an HCFA-1483) as a "medical and other health service." (See § 219).

For services furnished after October 30, 1972, which are not covered under one of the three provisions outlined above because they are found to be not reasonable and necessary, § 1879 of the Social Security law provides protection from liability for beneficiaries and/or home health agencies who did not know, and had no reason to know that the services were not covered.

If the beneficiary had knowledge or should have had knowledge of the noncoverage of the services, the ultimate liability will rest with the beneficiary. When neither the beneficiary nor the HHA knew or reasonably could have been expected to know that the services were not covered, the program will accept liability. Where the HHA had or should have had such knowledge and the beneficiary did not, liability will fall upon the HHA. When liability falls on an HHA, the HHA may not charge the beneficiary for such services, other than the Part B deductible and coinsurance amounts for "medical and other health services."

432. BILLING PROCEDURES FOR A HOME HEALTH AGENCY BEING ASSIGNED MULTIPLE PROVIDER NUMBERS OR A CHANGE IN PROVIDER NUMBER

Where a multiple-facility HHA is being assigned separate provider numbers for each component facility or where an HHA is being assigned a different number, the HHA is required to use the new number for any start of care notices, bills, etc., beginning with the date the new number is effective.

The old provider number should be used on billing forms for home health services through the day before the effective date of the new provider number. For services rendered on and after the effective date of the new provider number, the

HHA will use its new number when submitting bills or other information. The final billing form submitted under the old provider number should show "Discharge" in Item 19.

433. HOME HEALTH SERVICES AFTER TERMINATION OF PROVIDER AGREEMENT

Effective with the date a home health agency agreement is terminated, no payment will be made to the provider under such agreement for home health services furnished under a plan of treatment which was established on or after the termination date. However, if the plan was established before the termination date, Part A or Part B payment can be made for services furnished through December 31 of the calendar year in which the termination is effective. See § 146.

435. TRANSFER FROM PART A TO PART B HOME HEALTH SERVICES

A patient may elect to receive Part B home health services under the same home health plan of treatment after Part A visits are exhausted or the time limit for Part A (1 year) has expired. When the transfer from Part A visits to Part B visits occurs during the same benefit period, no start of care notice is to be submitted for the Part B home health services. On the bill covering the last Part A services, the "still receives services" block in Item 19 should be checked.

A. Services furnished prior to July 1, 1981

On the initial bill for Part B home health services, Items 10 and 13 will contain the same dates as on the billings for Part A services.

B. Services Furnished July 1, 1981 and Later

There is no limitation on the number of Part A or B visits nor a time limit on Part A. Since Part A visits will not be exhausted, transfer to Part B would be made only where termination of entitlement to Part A occurred. (See §§ 167 and 168.) In such cases complete the final Part A bill and the initial Part B bill as described in paragraph A above.

436. TRANSFER OF BILLING FROM PART B TO PART A HOME HEALTH SERVICES (SERVICES RENDERED PRIOR TO JULY 1, 1981 ONLY)

If a patient receiving Part B home health services prior to July 1, 1981, has a qualifying inpatient stay, the Part B home health plan is terminated and subsequent services should be billed under Part A. Services covered by Part A should not be submitted on the same billing form as services covered by Part B.

1. Completion of Final Part B Home Health Bill.—The bill submitted for the final services, covered by Part B should include the following items. (See § 450, Exhibit IX.)

Item 17. STATEMENT COVERS PERIOD ("TO" DATE).
Date of admission to the qualifying hospital or skilled nursing facility.

ITEM 19. PATIENT "STATUS".
The "Discharged" block should be checked.

ITEM 20. DATE APPLICABLE TO ITEM 19.
The same date as shown for the "To" date in Item 17 is entered.

2. Completion of Part A Start of Care Notice.—A start of care notice must be submitted and processed in the usual way. On this notice and on the Part A billing, Items 10, 13, and 17 should be completed as follows:

ITEM 10. DATE CARE STARTED.
The date on which care started under the Part A plan.

ITEM 13. DATE HOME HEALTH PLAN ESTABLISHED.
The date on which the new plan for visits under Part A was established.

ITEM 17. STATEMENT COVERS PERIOD ("FROM" DATE).
The date care started (item 10) under the Part A plan.

437. BILLING UNDER PART A OR PART B, JULY 1, 1981 AND AFTER

The Medicare law provides that payment may not be made under Part B where payment under Part A is possible. Therefore, all billings for services provided on or after July 1, 1981 must be made under Part A where the patient is entitled under Part A. Such billings should be handled as subsequent bills (i.e., information previously furnished need not be repeated and a start of care notice is not needed). Part B bills for home health services after July 1, 1981, may be submitted only when the beneficiary has no Part A entitlement.

438. EFFECT OF A NEW SPELL OF ILLNESS

A. Services Furnished Before July 1, 1981

If a beneficiary receiving Part A home health visits has an inpatient stay in a qualified institution occurring more than 60 days after his last discharge from an institution, a new spell of illness starts (see § 112.3) and his Part A plan of treatment is terminated. In this situation your intermediary may require a final no-payment bill in accordance with § 442. If your intermediary requires such a bill, the "Discharged" block in Item 19 will be checked and the first day of the inpatient stay entered in Item 20.

If the patient stay meets the prior stay requirements the new plan will be under Part A; if not, the plan must be under Part B. (See § 450, Example IV, for completion of the final billing.)

If a beneficiary receiving Part B home health visits has an inpatient stay which starts a new benefit period and meets the prior stay requirement, § 436 will be followed.

When prior stay requirements are not met, Part B visits are unaffected and can continue. See § 450, Exhibit VIII for subsequent billing.

In situations when a patient transfers from Part A visits to Part B visits under the same home health plan of treatment and in the same spell of illness, see § 435.

B. Services Furnished July 1, 1981 or Later

Effective July 1, 1981, later hospitalization has no effect on a plan of treatment.

Example VI

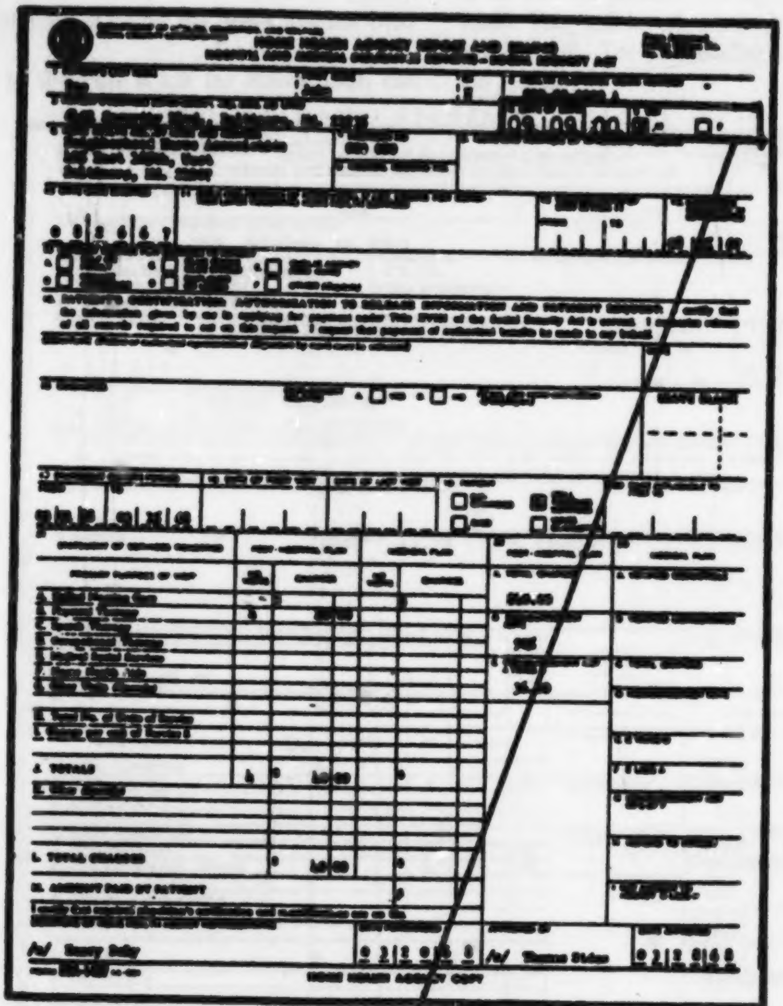
VI. FINAL BILLING--PART A--SERVICES WILL CONTINUE UNDER PART B BUT PART A VISITS EXHAUSTED

Mr. Doe receives Part A home health visits until March 15, 1968, when the 100 visits are exhausted. The home health agency now transfers him to Part B visits.

The agency must submit two bills for the month of March, one for the Part A visits and one for the Part B visits.

This example VI shows the information to be entered on the Part A bill.

See Example VII for the Part B bill.



Required for bills completed on or after 11/1/75.

Example VII

VII. INITIAL BILLING—PART B—PART A VISITS EXHAUSTED

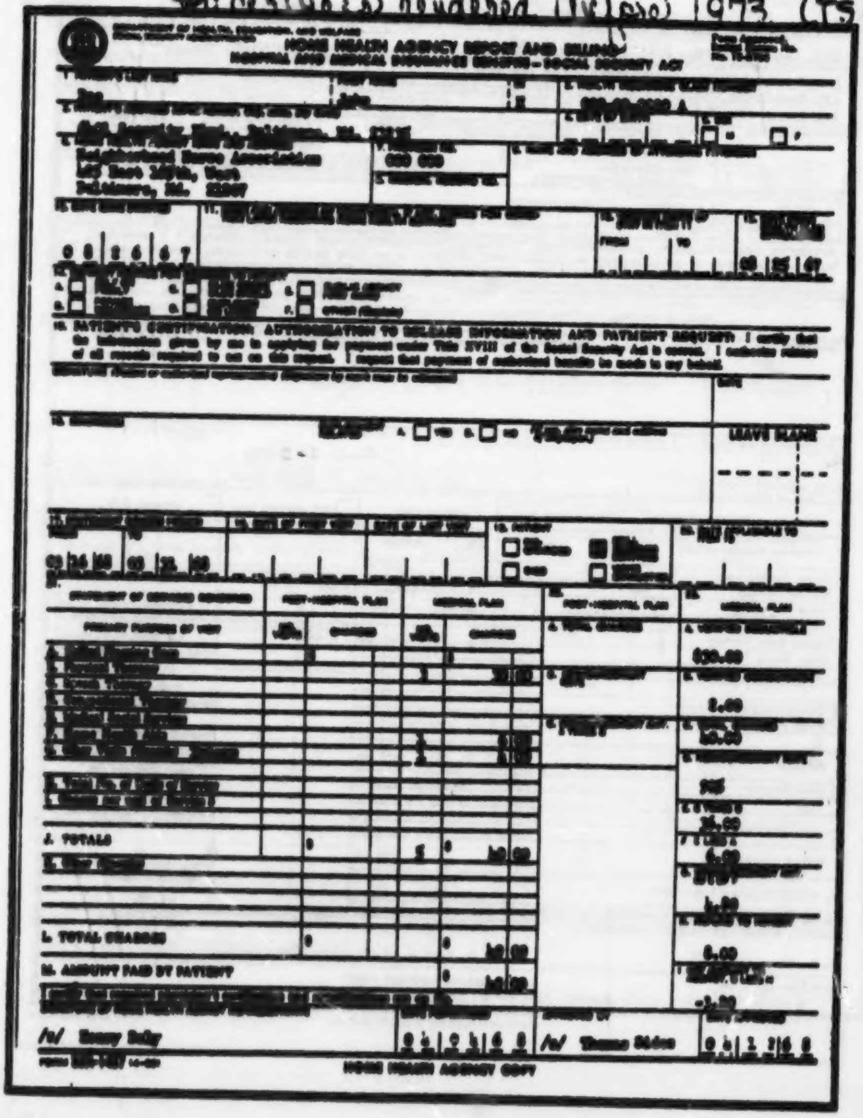
This example is the bill for Part B visits in March 1968.

The agency believes no part of the $50 Part B deductible has been met and prematurely collects the total charge of $40 from the patient. It does not complete Item 23 of the billing form, which the agency completes only when it knows the deductible has been met.

On receipt of the Part B bill for March 1968, the intermediary queries the SSA central record for deductible status. The reply shows $30 remaining to meet the Part B deductible for 1968.

The intermediary completes Item 23 to compute the reimbursement amount. A refund of $8 is determined to be due the patient. The agency has been overpaid $3.20. This will be adjusted when the agency submits another bill. The intermediary makes the refund to the patient.

[illegible] Rendered [illegible] 1973 (TS43)



HOME HEALTH AGENCY REPORT AND BILLING

HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

J. TOTALS

L. TOTAL CHARGES

M. AMOUNT PAID BY PATIENT

HOME HEALTH AGENCY COPY

Example VIII

VIII. SUBSEQUENT BILLING—PART B—LESS THAN 3-DAY HOSPITAL STAY

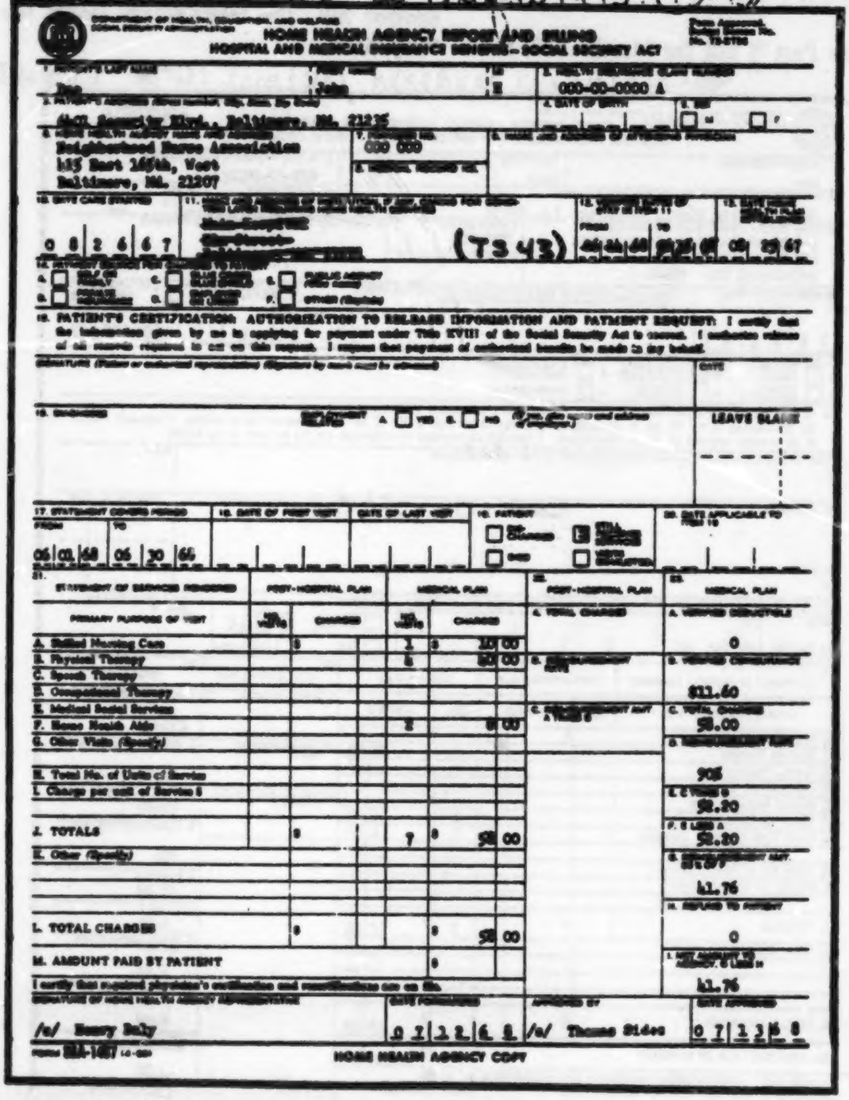
(TS43)

On June 14, 1968, the patient receives inpatient services in a hospital participating in medicare.

This inpatient hospital stay of less than 3 days starts a spell of illness, but does not entitle the patient to visits under Part A. ~~However, information about the stay is entered in Items 11 and 12 of the next bill.~~

Since the agency now knows that the Part B deductible was met by its last bill, it may complete Item 23 on this bill.

For services rendered before 1973. (TS 43)



HOME HEALTH AGENCY REPORT AND BILLING
HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

Doe | John | E | 000-00-0000 A

4401 Security Blvd., Baltimore, Md. 21235

Neighborhood Nurse Association
415 East 165th, West
Baltimore, Md. 21207

000 000

0 8 | 2 6 | 6 7

(TS 43)

LEAVE BLANK

17. STATEMENT COVERS PERIOD FROM 06 03 68 TO 06 30 68

STATEMENT OF SERVICES RENDERED — PRIMARY PURPOSE OF VISIT	POST-HOSPITAL PLAN — NO. VISITS	POST-HOSPITAL PLAN — CHARGES	MEDICAL PLAN — NO. VISITS	MEDICAL PLAN — CHARGES
A. Skilled Nursing Care		$	1	$ 10 00
B. Physical Therapy			4	40 00
C. Speech Therapy				
D. Occupational Therapy				
E. Medical Social Services				
F. Home Health Aide			2	8 00
G. Other Visits (Specify)				
H. Total No. of Units of Service				
I. Charge per unit of Service $				
J. TOTALS		$	7	$ 58 00
K. Other (Specify)				
L. TOTAL CHARGES		$		$ 58 00
M. AMOUNT PAID BY PATIENT				$

23. MEDICAL PLAN
A. VERIFIED DEDUCTIBLE: 0
B. VERIFIED COINSURANCE: $11.60
C. TOTAL CHARGES: 58.00
D. REIMBURSEMENT %: 90%
E. C TIMES D: 52.20
F. E LESS A: 52.20
G. REIMBURSEMENT AMT. 80% OF F: 41.76
H. REFUND TO PATIENT: 0
I. NET AMOUNT TO AGENCY: 41.76

I certify that required physician's certification and recertifications are on file.

/s/ Henry Daly | DATE FORWARDED 0 7 1 2 6 8 | APPROVED BY /s/ Thomas Sides | DATE APPROVED 0 7 1 3 6 8

FORM SSA-1487

HOME HEALTH AGENCY COPY

Example IX

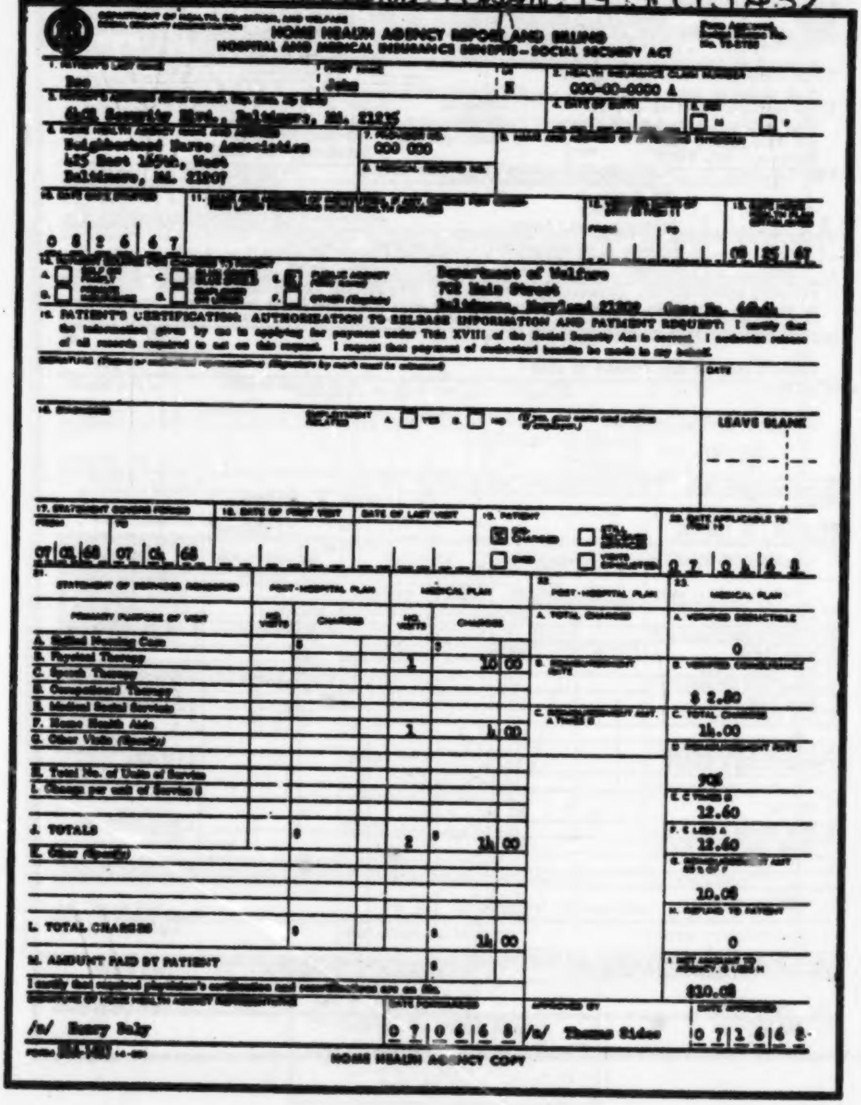
IX. FINAL BILLING—PART B—PATIENT QUALIFIES FOR PART A

From July 4, 1968, to July 8, 1968, Mr. Doe receives inpatient services in a nonparticipating hospital which meets all the conditions of participation. Since a spell of illness started as a result of the June hospitalization, this inpatient stay of 4 days entitles him to a new 100 Part A visits. A new plan must be established.

This example is the final Part B bill. The "To" date in Item 17 is the same date as shown in Item 20, i.e., the date of admission to the hospital.

Information has also been received by the agency that the Department of Welfare will pay for charges to the patient. The name and address of the agency as well as the case number assigned to the patient are shown in Item 14.

For services rendered before 1973. (TS #3)



HOME HEALTH AGENCY REPORT AND BILLING
HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

1. Doe | John | M
2. 000-00-0000 A
3. 4402 Security Blvd., Baltimore, Md. 21235
5. ☐ M ☐ F
6. Neighborhood Nurse Association
425 East 165th, West
Baltimore, Md. 21207
7. 000 000
10. 0 8 | 2 6 | 6 7
13. 08 | 25 | 67
14. A. ☐ B. ☐ C. ☐ D. ☐ E. ☒ PUBLIC AGENCY F. ☐ OTHER (Specify)
Department of Welfare
702 Main Street
Baltimore, Maryland 21202 Case No. 6841

15. PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.

SIGNATURE | DATE

16. DIAGNOSIS | A. ☐ YES B. ☐ NO | LEAVE BLANK

17. STATEMENT COVERS PERIOD FROM 07 | 03 | 68 TO 07 | 04 | 68
18. DATE OF FIRST VISIT | DATE OF LAST VISIT
19. PATIENT ☒ DIS-CHARGED ☐ ☐ DIED ☐
20. 0 7 | 0 4 | 6 8

21. STATEMENT OF SERVICES RENDERED	POST-HOSPITAL PLAN		MEDICAL PLAN	
PRIMARY PURPOSE OF VISIT	NO. VISITS	CHARGES	NO. VISITS	CHARGES
A. Skilled Nursing Care		$		$
B. Physical Therapy			1	10 00
C. Speech Therapy				
D. Occupational Therapy				
E. Medical Social Services				
F. Home Health Aide			1	4 00
G. Other Visits (Specify)				
H. Total No. of Units of Service				
I. Charge per unit of Service $				
J. TOTALS		$	2	$ 14 00
K. Other (Specify)				
L. TOTAL CHARGES		$		$ 14 00
M. AMOUNT PAID BY PATIENT				$

22. POST-HOSPITAL PLAN
A. TOTAL CHARGES
B.
C.

23. MEDICAL PLAN
A. VERIFIED DEDUCTIBLE 0
B. VERIFIED COINSURANCE $ 2.80
C. TOTAL CHARGES 14.00
D. REIMBURSEMENT RATE 90%
E. C TIMES D 12.60
F. E LESS A 12.60
G. 10.08
H. REFUND TO PATIENT 0
I. $10.08

I certify that required physician's certification and recertifications are on file.

/s/ Henry Baly | DATE FORWARDED 0 7 | 0 6 | 6 8 | APPROVED BY /s/ Thomas Sides | DATE APPROVED 0 7 | 1 3 | 6 8

HOME HEALTH AGENCY COPY

Example X

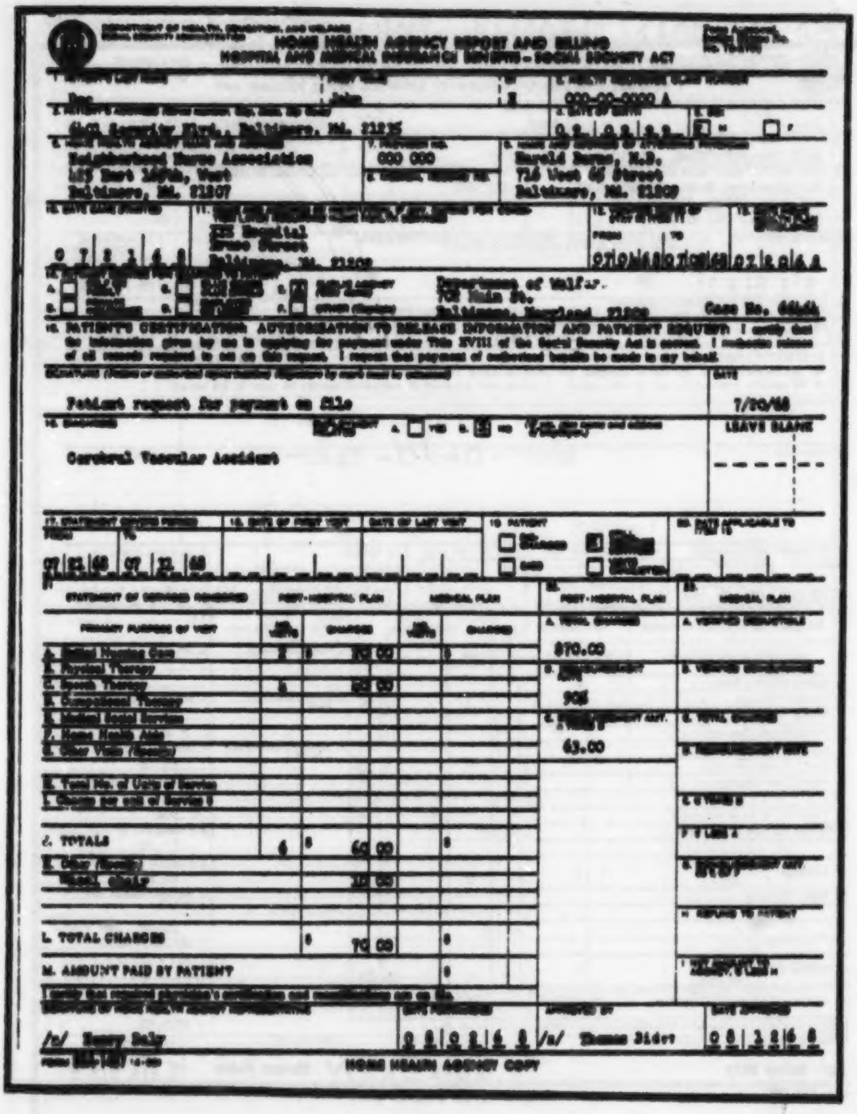
X. INITIAL BILLING—PART A—EQUIPMENT FURNISHED AS HOME HEALTH SERVICE

This is the initial Part A bill following the final Part B bill in Example IX. The agency submitted a start of care notice.

A Part A plan was established July 20, 1968, and care started July 21, 1968.

The home health agency, in addition to visits, is now furnishing a wheelchair to the patient. This is billed for in Item 21K.

Since services are now being furnished under a new home health plan, a new request for payment is required. The patient's signature has been obtained on the agency's record.



HOME HEALTH AGENCY REPORT AND BILLING

HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

Doe

John

000-00-0000 A

000 000

Department of Welfare

Patient request for payment on file

7/20/68

Cerebral Vascular Accident

LEAVE BLANK

07 21 68 07 31 68

$70.00

90%

63.00

J. TOTALS 6 $ 60 00

L. TOTAL CHARGES $ 70 00

M. AMOUNT PAID BY PATIENT $

HOME HEALTH AGENCY COPY

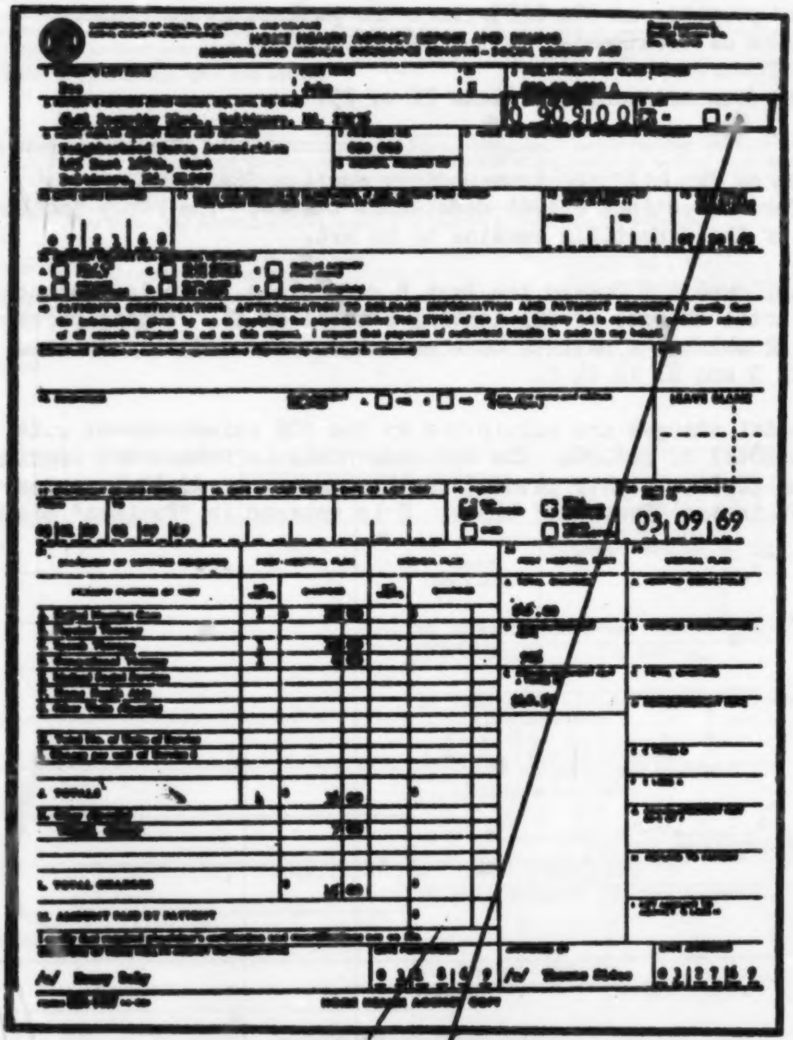
Example XI

XI. FINAL BILLING—PART A—PHYSICIAN TERMINATES PLAN—EQUIPMENT STILL NEEDED

On March 9, 1969, the patient's physician decides that visits are no longer necessary. However, the wheelchair will still be required.

The home health agency will rent the patient the wheelchair after March 9, 1969.

This example shows the last Part A billing form for services to March 9, 1969.



Required for bills completed on or after 11/1/75.

EXAMPLE XII

XII. BILLING FOR RENTAL OF EQUIPMENT - PART B

On March 10, 1969, the rental of the wheelchair takes effect. The rental of durable medical equipment is reimbursable on a cost basis under Part B. This example shows the billing form for the period March 10, 1969, through March 31, 1969.

The agency prepares an SSA-1483 since the patient is no longer under a plan of treatment.

The agency does not complete items 24 or 25.

On receipt of the bill the intermediary queries SSA central records for the patient's 1969 deductible status. The reply indicates that $16 of the deductible remains to be met.

The patient owes $16 toward the Part B deductible. $16 is subtracted from the total charges of $21 leaving a total of $5. Twenty percent of $5 is $1 which the patient owes as coinsurance. $16 is entered in Item 24 B and $1 in 24 C.

The $21 total charges are multiplied by the 90% reimbursement rate leaving a total of $18.90. The $16 deductible is subtracted leaving a total of $2.90. Eighty percent of this amount or $2.32 is entered in Item 25 in the "Provider" block. 0 is entered in "Patient" block.

EXHIBIT XII

PROVIDER BILLING FOR MEDICAL AND OTHER HEALTH SERVICES

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

Form Approved
[illegible]

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law.

1. Patient's last name: Doe | First name: John | MI: H
2. Health insurance claim number: 000-00-000A
3. Patient's address (Street number, City, State, ZIP Code): 6401 Security Blvd., Baltimore, Maryland 21235
4. Date of birth: 09 | 09 | 00
5. Sex: ☒ M ☐ F
6. Provider name and address (City and State):
Visiting Nurse Assn.
Baltimore, Maryland 21201
7. Provider number: 000000
8. Medical record number:
9. Type of service: A. ☐ Inpatient B. ☐ Outpatient C. ☒ Other (Specify) Home Health Agency

If you have other health insurance or if your State Medical Assistance Agency will pay part of your medical expenses and you want information about this claim released to them upon their request, complete items 10 and 11.

10. Insuring organization or State agency name and address:
11. Policy or medical assistance number:

12. Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related medicare claim. I request that payment of authorized benefits be made on my behalf.

☒ Contained in provider's record | Signature (Patient or authorized representative) (Signature by mark must be witnessed) | Date

13. Nature of illness or injury: Cerebral Vascular Accident
Partial paralysis of left side—Patient will require wheelchair for 6 months.
☐ Check here if illness or injury was connected with employment
Do not use this space

14. Surgical procedures:

15. Statement of services	Covered Charges	
A. Clinic visit ( )		
B. Emergency room ( )		
C. Laboratory		
D. Radiology		
E. Pharmacy		
F. Blood		
G. Ambulance		
H. Physical therapy		
I. Other (Specify)		
Rental of Wheel Chair *	21	00
J. TOTAL	21	00

16. Statement Covers Period: First service 03 | 10 | 72 Last service 03 | 31 | 72

17. Blood Information: A. Pints furnished | B. Pints replaced | Not Replaced: C. Pints | D. Charge per pint | E. Patient paid for deductible

18. Professional component (hospital inpatients): A. Pathology | B. Radiology

19. Other professional component

20. Date benefits exhausted or HH plan terminated: 03 | 09 | 72

21. Patient paid (Excluding 17E): 0

22. I certify that the required physician's certification is on file.

23. Date received: 04 | 05 | 72

FOR INTERMEDIARY USE ONLY

24. Verified Patient Liability: A. Blood deductible | B. Cash deductible | C. Coinsurance

25. Payment Distribution: Provider | Patient

26. Date approved

Remarks: *Summit Rental Agency
25 Paca St.
Baltimore, Maryland 21202

FORM SSA-1483 (1-70)

Department of Health, Education, and Welfare
Social Security Administration

450.1 Examples for Home Health Services Furnished After 1972.--

XIII. Subsequent Billing--Part B--Less Than 3-Day Hospital Stay--Services Rendered After 1972

XIV. Final Billing--Part B--Patient Qualifies for Part A--Services Rendered After 1972

EXAMPLE XIII:

XIII. SUBSEQUENT BILLING--PART B--LESS THAN 3-DAY HOSPITAL STAY--SERVICES RENDERED AFTER 1972

On June 14, 1973, the patient receives inpatient services in a hospital participating in Medicare.

This inpatient hospital stay of less than 3 days starts a spell of illness, but does not entitle the patient to visits under Part A.

Since the agency now knows that the Part B deductible was met by its last bill, it may complete Item 23 on this bill.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

EXHIBIT XIII

Form Approved
Budget Bureau No.
No. 72 - [illegible]

HOME HEALTH AGENCY REPORT AND BILLING
HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

[illegible]

1. PATIENT'S LAST NAME Doe	FIRST NAME John	MI R	2. HEALTH INSURANCE CLAIM NUMBER 000-00-0000 A
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code) 4401 Security Blvd., Baltimore, Md. 21235		4. DATE OF BIRTH 09 | 09 | 00	5. SEX ☒ M ☐ F
6. HOME HEALTH AGENCY NAME AND ADDRESS Neighborhood Nurse Association 425 East 165th, West Baltimore, Md. 21207	7. PROVIDER NO. 000 000 8. MEDICAL RECORD NO.	9. NAME AND ADDRESS OF ATTENDING PHYSICIAN	
10. DATE CARE STARTED 0 5 | 2 6 | 7 2	11. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES	12. VERIFIED DATES OF STAY IN ITEM 11 FROM TO	13. [illegible]

14. PAYMENT SOURCE FOR CHARGES TO PATIENT
A. ☐ [illegible] C. ☐ [illegible] E. ☐ PUBLIC AGENCY (Give name)
B. ☐ [illegible] D. ☐ [illegible] F. ☐ OTHER (Explain)

15. **PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.

SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed) DATE

16. DIAGNOSIS EMPLOYMENT RELATED A. ☐ YES B. ☐ NO (If yes, give name and address of employer.) LEAVE BLANK

17. STATEMENT COVERS PERIOD		18. DATE OF FIRST VISIT	DATE OF LAST VISIT	19. PATIENT	20. DATE APPLICABLE TO ITEM 19
FROM 06 | 01 | 73	TO 06 | 30 | 73			☐ DISCHARGED ☒ STILL RECEIVING SERVICES ☐ DIED ☐ VISITS DISCONTINUED	

21. STATEMENT OF SERVICES RENDERED	POST - HOSPITAL PLAN		MEDICAL PLAN	
PRIMARY PURPOSE OF VISIT	NO. VISITS	CHARGES	NO. VISITS	CHARGES
A. Skilled Nursing Care		$	1	$ 10.00
B. Physical Therapy			4	40.00
C. Speech Therapy				
D. Occupational Therapy				
E. Medical Social Services			2	8.00
F. Home Health Aide				
G. Other Visits (Specify)				
H. Total No. of Units of Service				
I. Charge per unit of Service $				
J. TOTALS		$	7	$ 58.00
K. Other (Specify)				
L. TOTAL CHARGES		$		$ 58.00
M. AMOUNT PAID BY PATIENT				$

22. POST - HOSPITAL PLAN
A. TOTAL CHARGES
B. REIMBURSEMENT RATE
C. REIMBURSEMENT AMT. (A TIMES B)

23. MEDICAL PLAN
A. VERIFIED DEDUCTIBLE 0
B. VERIFIED COINSURANCE
C. TOTAL CHARGES 58.00
D. REIMBURSEMENT RATE 90%
E. C TIMES D 52.20
F. E LESS A 52.20
G. REIMBURSEMENT AMT. [illegible] 52.20
H. REFUND TO PATIENT 0
I. NET AMOUNT TO AGENCY, G LESS H 52.20

I certify that required physician's certification and recertifications are on file.

SIGNATURE OF HOME HEALTH AGENCY REPRESENTATIVE	DATE FORWARDED	APPROVED BY	DATE APPROVED
/s/ Henry Daly	0 7 | 1 2 | 73	/s/ Thomas Sides	07 | 13 | 73

FORM SSA - 1487 (2)

Required for bills completed on or after 11/1/75.

Example XIV

XIV. FINAL BILLING--PART B--PATIENT QUALIFIES FOR PART A--SERVICES RENDERED AFTER 1972

From July 4, 1973, to July 8, 1973, Mr. Doe receives inpatient services in a nonparticipating hospital which meets all the conditions of participation. Since a benefit period started as a result of the June hospitalization, this inpatient stay of 4 days entitles him to a new 100 Part A visits. A new plan must be established.

This example is the final Part B bill. The "To" date in Item 17 is the same date as shown in Item 20, i.e., the date of admission to the hospital.

Information has also been received by the agency that the Department of Welfare will pay for charges to the patient. The name and address of the agency as well as the case number assigned to the patient are shown in Item 14.

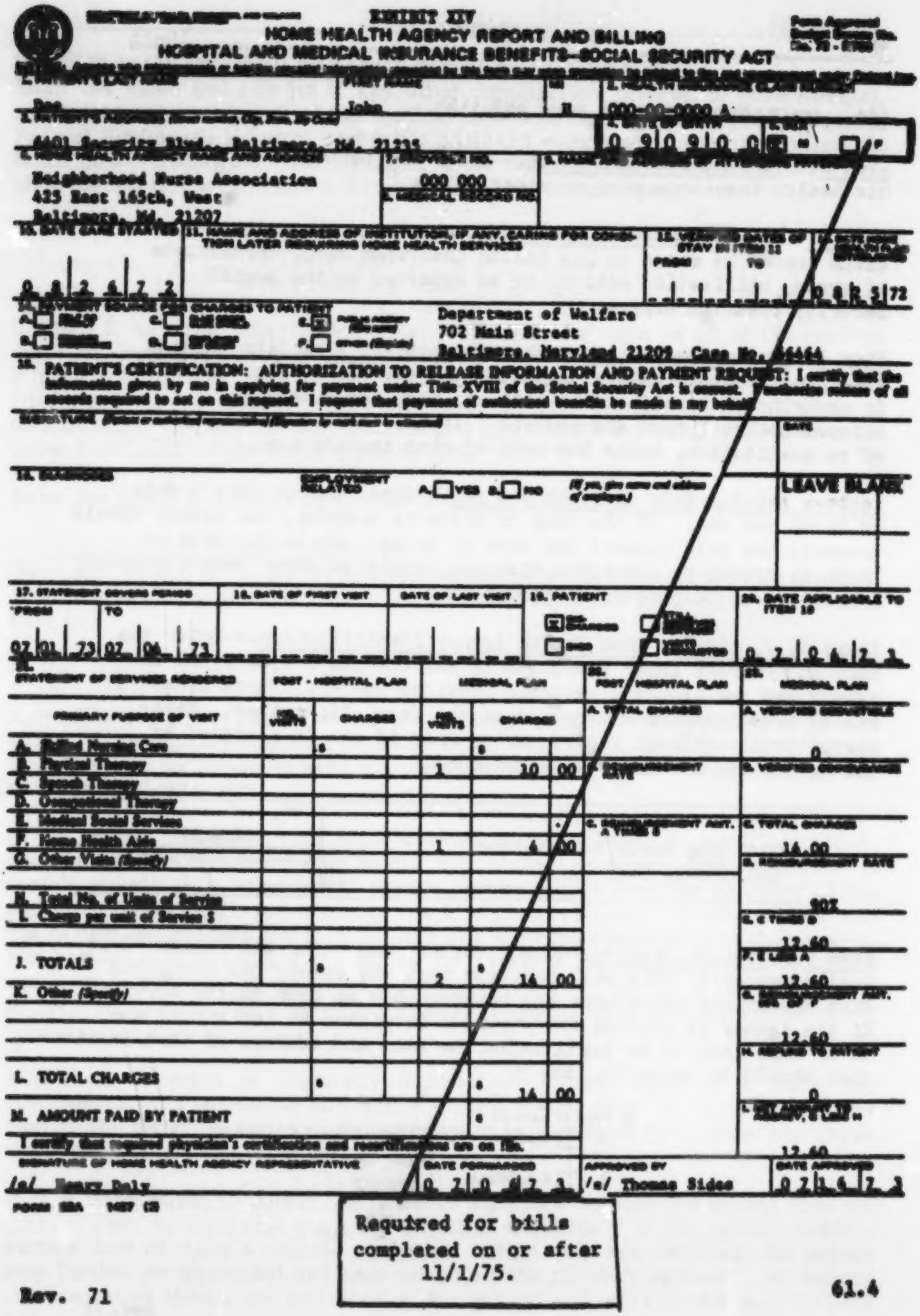


EXHIBIT XIV

HOME HEALTH AGENCY REPORT AND BILLING

HOSPITAL AND MEDICAL INSURANCE BENEFITS–SOCIAL SECURITY ACT

Form Approved
Budget Bureau No.
[illegible]

1. PATIENT'S LAST NAME: Doe
FIRST NAME: John
MI: H
2. HEALTH INSURANCE CLAIM NUMBER: 000-00-0000 A
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code): 4401 Security Blvd., Baltimore, Md. 21235
4. DATE OF BIRTH: 0 9 | 0 9 | 0 0
5. SEX: ☒ M ☐ F

6. HOME HEALTH AGENCY NAME AND ADDRESS:
Neighborhood Nurse Association
425 East 165th, West
Baltimore, Md. 21207

7. PROVIDER NO.: 000 000
8. MEDICAL RECORD NO.:
9. NAME AND ADDRESS OF ATTENDING PHYSICIAN:

10. DATE CARE STARTED: 0 8 | 2 6 | 7 2
11. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES:
12. VERIFIED DATES OF STAY IN ITEM 11: FROM | TO
13. [illegible]: 0 8 | 2 5 | 72

14. PAYMENT SOURCE FOR CHARGES TO PATIENT
A. ☐ [illegible]
B. ☐ [illegible]
C. ☐ [illegible]
D. ☐ [illegible]
E. ☒ PUBLIC AGENCY (Welfare)
F. ☐ OTHER (Explain)

Department of Welfare
702 Main Street
Baltimore, Maryland 21209 Case No. 66464

15. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.

SIGNATURE [illegible] | DATE

16. DIAGNOSES
EMPLOYMENT RELATED A. ☐ YES B. ☐ NO (If yes, give name and address of employer.)

LEAVE BLANK

17. STATEMENT COVERS PERIOD: FROM 07 | 01 | 73 TO 07 | 06 | 73
18. DATE OF FIRST VISIT:
DATE OF LAST VISIT:
19. PATIENT: ☒ [illegible] ☐ [illegible] ☐ [illegible] ☐ [illegible]
20. DATE APPLICABLE TO ITEM 19: 0 7 | 0 6 | 7 3

21. STATEMENT OF SERVICES RENDERED	POST - HOSPITAL PLAN		MEDICAL PLAN	
PRIMARY PURPOSE OF VISIT	NO. VISITS	CHARGES	NO. VISITS	CHARGES
A. Skilled Nursing Care		$		$
B. Physical Therapy			1	10 00
C. Speech Therapy				
D. Occupational Therapy				
E. Medical Social Services				
F. Home Health Aide			1	4 00
G. Other Visits (Specify)				
H. Total No. of Units of Service				
I. Charge per unit of Service $				
J. TOTALS		$	2	$ 14 00
K. Other (Specify)				
L. TOTAL CHARGES		$		$ 14 00
M. AMOUNT PAID BY PATIENT				$

22. POST - HOSPITAL PLAN
A. TOTAL CHARGES
B. REIMBURSEMENT RATE
C. REIMBURSEMENT AMT. A TIMES B

23. MEDICAL PLAN
A. VERIFIED DEDUCTIBLE: 0
B. VERIFIED COINSURANCE:
C. TOTAL CHARGES: 14.00
D. REIMBURSEMENT RATE: 90%
E. C TIMES D: 12.60
F. E LESS A: 12.60
G. REIMBURSEMENT AMT. [illegible] F: 12.60
H. REFUND TO PATIENT: 0
I. [illegible] AGENCY, G LESS H: 12.60

I certify that required physician's certification and recertifications are on file.

SIGNATURE OF HOME HEALTH AGENCY REPRESENTATIVE: /s/ Henry Daly
DATE FORWARDED: 0 7 | 0 6 | 7 3
APPROVED BY: /s/ Thomas Sides
DATE APPROVED: 0 7 | 1 6 | 7 3

FORM SSA 1487 (2)

Required for bills completed on or after 11/1/75.

460. COMPLETING ITEMS ON FORM SSA-1483

Item 1. Patient Identification.--Enter the patient's name from his health insurance card or other notice.

Item 2. Health Insurance Claim Number.--Enter the patient's claim number as shown on his health insurance card, certificate of award, utilization notice, or as reported by the social security district office.

Item 3. Patient's Address.--Show the patient's mailing address from your records. Where the patient's authorized representative is applying on behalf of the patient, show the authorized representative's name and address. If the patient is an inpatient of an institution, enter the name of that institution.

Items 4 and 5. Date of Birth and Sex.--Enter the patient's date of birth and sex. If the date of birth is unknown, the agency should transmit the bill without the date of birth. While the date of birth is useful as identification and should be shown when available, a billing can be processed without it.

Items 6, 7, and 8. Home Health Agency Identification.--Enter the name and address (city and State is all that is necessary) of the agency and the agency's assigned provider number. These items can be preprinted on all copies of the form, if desired. Enter the patient's medical record number only if one is assigned by the agency for its own filing purposes.

6. Provider name and address *(City and State)*	7. Provider number
Visiting Nurse Association Baltimore, Md. 21235	000000
	8. Medical record number

Item 9. Type of Service.--Check "Other" and enter the remark "Home Health Agency." This will indicate that the agency has furnished Part B services which were not reimbursable as home health services. If the agency is billing for services furnished an individual who is an inpatient of an institution, the name and address of that institution should be shown in item 3.

9. Type of service
A. ☐ Inpatient
B. ☐ Outpatient
C. ☒ Other *(Specify)* Home Health Agency

ITEMS 10 and 11. OTHER INSURANCE COVERAGE INFORMATION. Elicit the name and address of any other organization, private, or governmental, that might pay some or all of the medical expenses, e.g., worker's compensation or Federal Employee's Hospital Benefits (FEHB) and enter this information in Item 10. If an abbreviation is frequently used, enter the full name and address of the organization and put the abbreviation to the right, for example:

Federal Employee's Hospital Benefits (FEHB)
100 Eye Street
Hyde, Maryland 21201

If there is no other organization which might pay for some or all of the medical expenses, or the patient or his authorized representative refuses to give that information, or the information is unknown, enter in Item 10 either "None," "Refuses," or "Unknown." Note: Refusal to disclose whether worker's compensation will pay for medical expenses could result in a penalty being imposed under § 1877(a)(3) of the Social Security Act.

Enter the policy or identifying number in Item 11 when it can be obtained.

ITEM 12. PATIENT'S CERTIFICATION Have the patient or his authorized representative read the statement on the form or on the agency's record if it uses the alternate signature procedure. (See § 420, Item 15.)

If the agency obtains the signature on its own form, check the block marked "Contained in provider's record." If the signature is obtained on form HCFA-1483, it is sufficient if it is legible on the original only. A signature is required with each billing. If the agency obtains a signature on its own record, it will remain effective as long as the particular service is being received from the same agency according to the physician's order.

If the patient cannot sign his name because of his physicial or mental condition, another person may sign on his behalf, e.g., John J. Jones by Jack A Smith. In certain situations, a home health agency representative may sign on behalf of the patient. (See § 234ff. for who may file a payment request.) Briefly explain why the patient did not sign the form himself and show the relationship of the signer to the patient. This explanation should be retained in the agency's file if the signature is obtained on the home health agency's own record. If the signature is on form HCFA-1483, the explanation should accompany or be included on the billing form.

Where an illiterate or physically handicapped patient signs by a mark, the statement should be read to him, and a witness should enter his name and address next to the mark. A signature by mark should be witnessed by a person who knows the patient.

If it is impractical to obtain the patient's signature because the agency does not make a visit to his home (e.g., the physician certifies that the patient needs a certain item of durable medical equipment but no visits are certified), the agency may furnish the equipment and need not obtain the patient's signature. An agency representative should sign on behalf of the patient and write in this item "patient not visited."

ITEM 13 NATURE OF ILLNESS OR INJURY.

Enter the diagnosis as furnished by the attending physician.

While all narrative diagnoses should be shown in accordance with recognized nomenclature; e.g., Standard Nomenclature of Diseases and Operations, Current Medical Terminology, etc. Home Health Agencies are encouraged to use the International Classification of Diseases, 9th Revision - Clinical Modification (ICD-9-CM).

For all health insurance claim numbers (including those ending in "0", "4", "5", or "8") Home Health Agencies may, with the intermediary's concurrence report ICD-9-CM codes for diagnoses instead of narratives. The codes must be the full ICD-9-CM diagnosis codes, including all 5-digit codes. List the most significant diagnosis code first, then codes for up to four additional conditions that co-exist. Separate the codes with commas. When the full ICD-9-CM codes are used, do not report the narratives. In all other instances, the original narratives must be reported and should not be translations of codes.

When equipment has been sold to a beneficiary, enter "medical necessity (no.) months." This certifies that a physician's prescription indicates the required period of medical necessity for the equipment.

If the condition was employment related, check the block and show the name and address of the employer, if known. Where the agency knows that a worker's compensation claim has been made, it should insert or attach a statement identifying the carrier, if any, handling the worker's compensation claim, and give any available details about the claim. (See § 250ff. for additional information.)

ITEM 14. SURGICAL PROCEDURES.

No entry should be made in this item.

ITEM 15. STATEMENT OF SERVICES RENDERED.

Enter the covered Part B charges for "medical and other health services" furnished the patient (see §§ 219 and 220 for those items and services which are covered). If the service was furnished under arrangements with suppliers outside the agency, but is being billed by the agency, the HHA will show the services furnished under arrangement on the appropriate line on Item 15 the same way as other services.

Home Health agencies should make no entry in A. Clinic Visit, B. Emergency Room, C. Laboratory, D. Radiology, E. Pharmacy, F. Blood.

ITEM 15G. AMBULANCE

In addition to the information ordinarily shown on the HCFA-1483, the home health agency should furnish the intermediary with the following data for ambulance claims:

1. Detailed statement of the condition necessitating ambulance service;
2. Statement by provider indicating whether or not the patient was admitted as an inpatient. If applicable, show name and address of facility;

3. Name and address of certifying physician;
4. Name and address of physician ordering service if other than certifying physician;
5. Point of pickup (identify place and complete address);
6. Destination (identify place and complete address);
7. Number of miles;
8. Cost per mile;
9. Mileage Charge;
10. Minimum or base charge;
11. Charge for special items or services, explain. (See § 221.1C.)

The intermediary will advise the home health agency as to any special procedure for submitting the required information.

ITEM 15I. OTHER.
Durable Medical Equipment Charges:
Describe the equipment, show the monthly charge for rentals and the full purchase price for purchases, where equipment is for use in the patient's home. If used equipment is purchased on or after October 1, 1977, and the criteria is met for waiver of the 20 percent coinsurance enter "used" and "waiver" when describing the equipment.

Outpatient Speech Pathology Services should be shown on this line also.

ITEM 15J. TOTAL.
Show total covered charges.

ITEM 16. STATEMENT COVERS PERIOD.
Enter the dates of the first and last service furnished during the billing period. The billing period must not span two calendar years, since the cash deductible applies to the charges incurred in each year independently.

Expenses incurred in the last 3 months of a year which were applied toward the cash deductible for that year are carried over and applied toward the cash deductible for the next year. Therefore, where part of the cash deductible is satisfied in the last 3 months of the year, the HHA should not include expenses incurred in both the last calendar quarter and a preceding quarter on the same bill. However, if the agency knows that all of the Part B cash deductible was met before the last quarter, it is permissible to include expenses incurred in the last calendar quarter for a preceding quarter on the same bill. (See § 401 for billing charges for services provided in different accounting years.)

ITEM 17. BLOOD INFORMATION
Make no entry.

ITEM 18. PROFESSIONAL COMPONENT (HOSPITAL INPATIENTS).
Make no entry.

ITEM 19. OTHER PROFESSIONAL COMPONENT
Make no entry.

ITEM 20. DATE BENEFITS EXHAUSTED OR HOME HEALTH PLAN TERMINATED.
Enter a date only when home health visits were exhausted prior to July 1, 1981 or the physician's plan of treatment is terminated.

ITEM 21. PATIENT PAID.
Enter the amount, if any, paid by the patient. Do not include any amount paid by separate billing for physicians' services.

ITEM 22. SIGNATURE OF AGENCY REPRESENTATIVE.
Before the billing is forwarded to the intermediary, an agency representative should assure himself that the physician's certification as to medical necessity is on file. The representative should sign his name; a stamped signature is acceptable. (See § 219.4 for the physician certification requirements for outpatient physical therapy and speech pathology services and § 224 for the certification requirements for other Part B services.)

ITEM 23. DATE RECEIVED.
This block should be left blank. It is completed by the intermediary.

ITEMS 24, 25, AND 26.
For intermediary use only.

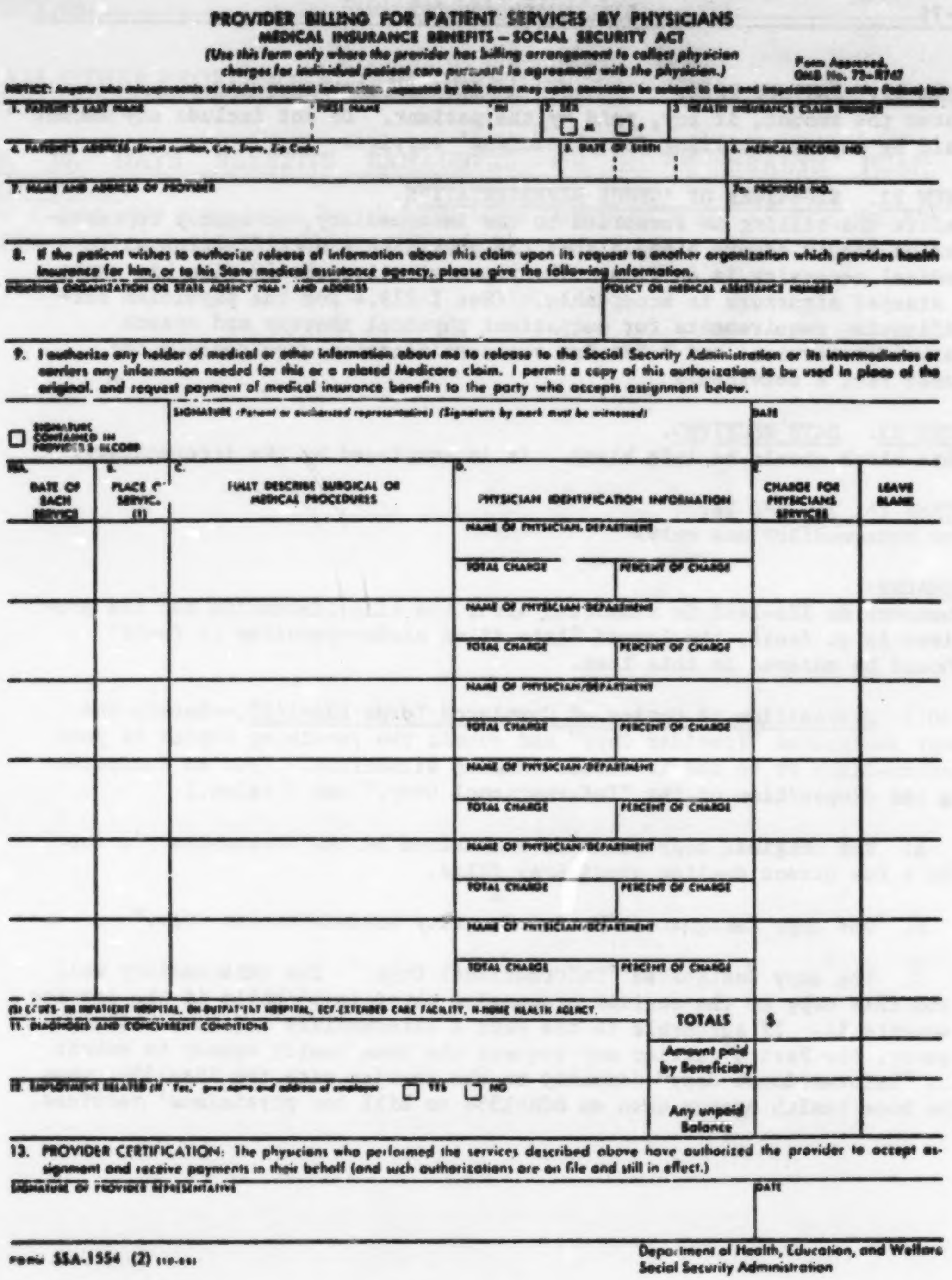
REMARKS:
Whenever an SSA-1483 is submitted after the time limitation and the provider is at fault, the legend "late filed claim--provider at fault" should be entered in this item.

460.1 Disposition of Copies of Completed Forms SSA-1483.--Retain the copy designated "Provider Copy" and submit the remaining copies to your intermediary or to SSA in direct dealing situations. (For an exception in the disposition of the "Informational Copy," see C below.)

A. The original copy which is maintained in the intermediary's (or SSA's for direct dealing providers) files.

B. One copy designated "Social Security Administration Copy."

C. The copy designated "Informational Copy." The intermediary will send this copy to the carrier processing physicians' bills if the carrier requests it. If agreeable to the Part A intermediary and home health agency, the Part B carrier may request the home health agency to submit the "Informational Copy" directly to the carrier with the SSA-1554, when the home health agency uses an SSA-1554 to bill for physicians' services.



PROVIDER BILLING FOR PATIENT SERVICES BY PHYSICIANS

MEDICAL INSURANCE BENEFITS – SOCIAL SECURITY ACT

(Use this form only where the provider has billing arrangement to collect physician charges for individual patient care pursuant to agreement with the physician.)

Form Approved,
OMB No. 72–R747

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law

1. PATIENT'S LAST NAME | FIRST NAME | MI
2. SEX ☐ M ☐ F
3. HEALTH INSURANCE CLAIM NUMBER
4. PATIENT'S ADDRESS (Street number, City, State, Zip Code)
5. DATE OF BIRTH
6. MEDICAL RECORD NO.
7. NAME AND ADDRESS OF PROVIDER
7a. PROVIDER NO.

8. If the patient wishes to authorize release of information about this claim upon its request to another organization which provides health insurance for him, or to his State medical assistance agency, please give the following information.

INSURING ORGANIZATION OR STATE AGENCY NAME AND ADDRESS | POLICY OR MEDICAL ASSISTANCE NUMBER

9. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment below.

☐ SIGNATURE CONTAINED IN PROVIDER'S RECORD

SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed) | DATE

10A. DATE OF EACH SERVICE	B. PLACE OF SERVICE (1)	C. FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES	D. PHYSICIAN IDENTIFICATION INFORMATION	E. CHARGE FOR PHYSICIANS SERVICES	LEAVE BLANK
			NAME OF PHYSICIAN/DEPARTMENT TOTAL CHARGE PERCENT OF CHARGE		
			NAME OF PHYSICIAN/DEPARTMENT TOTAL CHARGE PERCENT OF CHARGE		
			NAME OF PHYSICIAN/DEPARTMENT TOTAL CHARGE PERCENT OF CHARGE		
			NAME OF PHYSICIAN/DEPARTMENT TOTAL CHARGE PERCENT OF CHARGE		
			NAME OF PHYSICIAN/DEPARTMENT TOTAL CHARGE PERCENT OF CHARGE		
			NAME OF PHYSICIAN/DEPARTMENT TOTAL CHARGE PERCENT OF CHARGE		

(1) CODES- IH-INPATIENT HOSPITAL, OH-OUTPATIENT HOSPITAL, ECF-EXTENDED CARE FACILITY, H-HOME HEALTH AGENCY.

11. DIAGNOSIS AND CONCURRENT CONDITIONS

12. EMPLOYMENT RELATED (If "Yes," give name and address of employer) ☐ YES ☐ NO

TOTALS	$
Amount paid by Beneficiary	
Any unpaid Balance	

13. PROVIDER CERTIFICATION: The physicians who performed the services described above have authorized the provider to accept assignment and receive payments in their behalf (and such authorizations are on file and still in effect.)

SIGNATURE OF PROVIDER REPRESENTATIVE | DATE

FORM SSA-1554 (2) (10-69)

Department of Health, Education, and Welfare
Social Security Administration

Uniform Billing

475. COMPLETION OF FORM HCFA-1450 FOR HOME HEALTH AGENCY BILLING

The HCFA-1450 (also known as the UB-82) is a uniform institutional provider bill suitable for use in billing multiple third party payers. HCFA plans to implement this form for Medicare in lieu of HCFA-1483 and 1487 by October 1, 1985. The HCFA-1450 contains all data elements contained on the HCFA-1483 and 1487. In addition, a number of data elements not required by Medicare, but required by other payers, are included. For Medicare billing, complete only the information required by Medicare. When billing multiple third parties complete all items required by each payer, and forward a copy to each payer.

Item 1. (Untitled) Provider Name, Address, and Telephone Number
The minimum entry is the agency's name, city, State, and zip code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine-digit zip codes are acceptable. This information is used in connection with the Medicare provider number (item 7) to verify provider identity.

Item 2. Untitled
Not required. This is one of four fields on the form reserved for use within a State by the State Uniform Bill Committee, where one exists. Once such assignment is made within a State, that item may be used only for the designated purpose.

Item 3. Patient Control Number
Not required. The patient's control number may be shown if you assign one and need it for association and reference purposes.

Item 4. Type of Bill
This three-digit numeric code gives three specific pieces of information. The first identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.

Code Structure (only codes used to bill Medicare are shown).

1st Digit-Type of Facility
3 - Home Health

2nd Digit-Bill Classification
3 - Outpatient (Includes Part A or Part B visits under a plan of treatment and use of DME under a Part A plan of treatment.)

4 - Other (Part B) (Includes medical and other health services not under a plan of treatment. See §219 for description.)

3rd Digit-Frequency	Definition
1-Admit Through Discharge Claim	Enter this code for a bill which is expected to be the only bill to be received for a total course of treatment.
2-Interim-First Claim	Enter this code for the first of an expected series of payment bills for the same course of treatment.
3-Interim-Continuing Claim	Enter this code when a payment bill for the same course of treatment has already been submitted and further bills are expected to be submitted at a later date.
4-Interim-Last	Enter this code for a payment bill which is the last of a series for this course of treatment. The "Through" date of this bill (item 22) is the discharge date.
7-Replacement of Prior Claim	Enter this code to correct a previously submitted bill. Use this code for the corrected or "new" bill.
8-Void/Cancel of a Prior Claim	Enter this code if the bill is an exact duplicate of an incorrect bill previously submitted. Submit a code "7" (Replacement of Prior Claim) showing corrected information.

See §445 as to when it is necessary to submit a corrected bill. Your intermediary will instruct you on the coding to use and processing of adjustment bills consistent with its system.

Item 5. Blue Cross/Blue Shield Provider Number
Not required.

Item 6. Federal Tax Number
Not required.

Item 7. Medicare Provider Number
Enter the six-digit number assigned by Medicare.

Item 8. Medicaid Provider Number
Not required.

Item 9. Untitled
See item 2 above.

Item 10. Patient Name
Enter the patient's last name, first name, and middle initial.

Item 11 Patient Address
Enter the patient's full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP code.

Item 12. Birthdate
Enter the month, day, and year of birth (MM-DD-YY) of patient. If the full correct date is not known, leave blank.

Item 13. Sex
Enter the sex of the patient as recorded on the date care started. Use the following codes:

M=Male
F=Female

Item 14. Patient Marital Status
Not required.

Item 15. Admission Date (Start of Care Date)
Not required.

Item 16. Admission Hour
Not required.

Item 17. Type of Admission
Not required.

Item 18. Source of Admission
Not required.

Item 19. Accident Hour
Not required.

Item 20. Discharge Hour
Not required.

Item 21. Patient Status
Enter the code indicating the patient's status as of the "Through" date in item 22.

Code	Structure
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to a short-term general hospital
03	Discharged/Transferred to SNF
04	Discharged/transferred to an ICF

05	Discharged/transferred to another type of institution (including distinct parts)
06	Discharged/transferred to home under care of another organized home health service organization
07	Left against medical advice
20	Expired (or did not recover - Christian Science Patient)
30	Still patient

Item 22. Statement Covers Period
Enter the beginning and ending dates of the period covered by this bill as (MM-DD-YY). Enter the date of discharge or death in the space provided under "Through." Bills may not span two accounting years.

Item 23. Covered Days
Not required.

Item 24. Noncovered Days
Not required.

Item 25. Coinsurance Days
Not required.

Item 26. Lifetime Reserve Days
Not required.

Item 27. (Untitled)
See item 2 above.

Use of Occurrence and
Occurrence Span Fields (Items 28-33, Below)

Due to the varied nature of occurrence and occurrence span codes, provisions have been made to allow the use of both type codes within each. The occurrence span code can contain an occurrence code where the "Through" date would not contain an entry. This allows the use of as many as six occurrence codes.

When item 33 is utilized, items 31 and 32 may be utilized to contain the "From" and "Through" dates of an occurrence span code. In this case, the code in item 31 is the occurrence span code and the occurrence span "From" date is in the date field. Item 32 contains the same occurrence span code as the code in item 31 and the occurrence span "Through" date is the date field.

This scheme necessitates that the occurrence and occurrence span codes be mutually exclusive. Occurrence codes have values from 01 through 69 and occurrence span codes have values from 70 through 99.

Items 28, 29, 30, 31, and 32. Occurrence Codes and Dates

Enter the appropriate codes and dates from the table below where one or more occurrences are applicable. If there are more occurrences than there are spaces on the form, use item 33 (Occurrence Span) or item 94 (Remarks) to add additional occurrences and dates.

NOTE: There are occurrences on which other payers require reporting that are not shown below. Only Medicare requirements are included. Occurrence codes 01-03 and 24 are required only when claiming a conditional payment from Medicare and must be accompanied by the entry of the appropriate value code in items 46-49.

Code	Title	Definition
01	Auto Accident	Enter the date of an auto accident affecting this billing. (See §494.)
02	Auto Accident/No Fault Insurance Involved	Enter the date of an auto accident affecting this billing occurring in a State that has applicable no-fault liability laws. (See §494.)
03	Accident/Tort Liability	Enter the date of an accident affecting this billing resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party (other than no fault liability). (See §494.)
04	Accident/Employment Related	Enter the date of an accident affecting this billing, which allegedly relates to the patient's employment. (See §§250ff.)
05	Other Accident	Enter the date of an accident affecting this billing, not described by any of the preceding occurrence codes.
24	Date Insurance Denied	Enter the date of receipt of a denial of coverage by a higher priority payer.
27	Date HHA Plan Established or Last Reviewed	Enter the date a plan of treatment was established or last reviewed for home health services.
28	Date CORF Plan Established or Last Reviewed	Enter the date a plan of treatment was established or last reviewed for CORF care.
29	Date OPT Plan Established or Last Reviewed	Enter the date a plan was established or last reviewed for OPT.
30	Date Speech Pathology Plan Established or Last Reviewed	Enter the date a plan was established or last reviewed for speech pathology.
33	First Month of the 12 Month Coordination Period for ESRD Beneficiaries Covered by EGHP	Code indicates the first day of the first month of the 12 month period, as defined in §252.2D, during which Medicare benefits are secondary

to benefits payable under an EGHP. Required only for ESRD beneficiaries.

Other codes may be required by other payers, and while they are not used by Medicare, they may be entered on the bill if convenient.

Item 33. Occurrence Span Code and Dates

Enter code and associated beginning and ending dates defining a specific event relating to this billing period. Event codes are two numeric digits and dates are shown as MM-DD-YY.

Code	Title	Definition
72	First/Last Visit	Enter this code to indicate the dates of the first and last visits occurring in this billing period where these dates are different from those in item 22, Statement Covers Period.

Item 34. (Untitled except on Patient Copy of the bill) Responsible Party Name and Address

Not required. Space is provided for use of a window envelope if you use the patient's copy of the bill set. For claims which involve payers of higher priority than Medicare as defined in Item 65, enter the address of the other payer in this item or Item 94 (Remarks).

Items 35, 36, 37, 38, 39. Condition Codes

Enter the corresponding code to describe any of the following conditions that apply to this billing period.

Code	Title	Definition
02	Condition is Employment Related	Enter this code if the patient alleges that the medical condition causing this episode of care is due to environment/events resulting from his employment. (See §250 for workers' compensation and for Black Lung.)
04	Patient is HMO Enrollee	Enter this code to indicate the patient is a member of a Health Maintenance Organization. (See §412.)
07	Treatment of Nonterminal Condition for Hospice Patient	Enter this code if the patient has elected hospice care but the provider is not treating his terminal condition and is therefore requesting regular Medicare reimbursement.

Item 40. Pints of Blood Furnished

Not required.

Item 41. Pints of Blood Replaced

Not required.

Item 42. Pints of Blood Not Replaced
Not required.

Item 43. Blood Deductible Pints
Not required.

Item 44. Special Program Indicator
The only special program indicator that applies to Medicare is:

Code	Title	Explanation
06	PPV/Medicare 100-Percent Payment	Enter this code for bill classification type 4 (item 4) (medical and other health services) bills to show that pneumococcal pneumonia vaccine (PPV) given will be reimbursed at 100 percent without deductible or coinsurance. (See §A461.)

Item 45. Untitled
See item 2, above.

Items 46, 47, 48, and 49. Value Codes and Amounts
Code(s) and related dollar amount(s) identify data of a monetary nature necessary for the processing of this claim. The codes are two numeric digits, and each value allows up to eight numeric digits (000000.00). Negative amounts are never shown. If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. There are two lines of data, line "a" and line "b." Use items 46a through 49a before items 46b through 49b (i.e., the first line is used before the second line).

Code	Title	Definition
12	Working Aged Beneficiary/Spouse With Employer Group Health Plan	Indicates the amount shown is that portion of a higher priority employer group health insurance payment made on behalf of an aged beneficiary that the agency is applying to covered Medicare charges on this bill. Enter six zeros (0000.00) in the amount field, if claiming a conditional payment because the employer group health plan has denied coverage. (See §496.)
13	ESRD Beneficiary in the 12 Month Coordination Period With An Employer Group Health Plan	Indicates the amount shown is that portion of a higher priority employer group health insurance payment made on behalf of an ESRD beneficiary that the agency is applying to covered Medicare charges on this bill. Enter six zeros

		(0000.00) in the amount field, if claiming a conditional payment because the employer group health plan has denied coverage or there has been a substantial delay in its payment. (See §495.)
14	Automobile, No-Fault or Any Liability Insurance	Indicates the amount shown is that portion of a higher priority automobile, no-fault or liability insurance payment made on behalf of a Medicare beneficiary that the agency is applying to covered Medicare charges on this bill. Enter six zeros (0000.00) in the amount field, if claiming a conditional payment because the other insurer has denied coverage or there has been a substantial delay in its payment. (See §494.)
15	Workers' Compensation Including Black Lung	Indicates the amount shown is that portion of a higher priority workers' compensation insurance payment made on behalf of a Medicare beneficiary that the agency is applying to covered Medicare charges on this bill. Enter six zeros (0000.00) in the amount field, if claiming a conditional payment because there has been a substantial delay in the other insurer's payment. (See §250.)
16	VA, PHS, Other Federal Agency	Indicates the amount shown is that portion of a higher priority Veteran's Administration, Public Health Service, or other Federal Agency's payment made on behalf of a Medicare beneficiary that the agency is applying to covered Medicare charges on this bill. (See §232.3D.)

Item 50. Revenue Description
Enter narrative description or standard abbreviation for each revenue code shown in column 51 on the adjacent line in column 50. The information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes shown in Addendum C. "Other" code categories must be individually described on each bill.

When using this form for DME billing, identify the specific piece of DME on the line adjacent to revenue codes 291, 292, or 293, as appropriate. This description may be narrative or, if preferred by your intermediary HCPCS (HCFA Common Procedure Coding

System) codes. If HCPCS is required by your intermediary, it will supply you with an appropriate list of codes. See also Item 94, Remarks with reference to DME billing.

Item 51. Revenue Code
Enter the appropriate revenue codes from Addendum C to identify specific charges. Enter the three-digit numeric revenue code on the adjacent line in column 51 to explain each charge in column 53. This data takes the place of fixed line item descriptions on the billing form.

Additionally, there is no fixed "Total" line in the charge area. Enter revenue code "001" instead in column 51. Thus the adjacent charge entry in column 53 is the sum of charges billed. This will be the same line on which charges, if any, in columns 54-56 are summed.

To assist in bill review, list revenue codes in ascending numeric sequence to the extent possible. Do not repeat revenue codes on the same bill. To limit the number of line items on each bill, sum revenue codes at the "zero" level to the extent possible.

Do not use revenue code series 10X-26X, 28X, 30X-41X, 45X-54X, 60X-99X.

Detailed level of coding is always required when using the 29X revenue code series.

Item 52. Units of Service
Enter the number of visits or units of service on the line adjacent to revenue code and description where appropriate. Provide the number of units or visits as applicable.

Enter up to three numeric digits.

Item 53. Total Charges
Sum the total covered charges for the billing period by revenue code (column 51) and enter them on the adjacent line in column 53. The last revenue code entered in column 51, "001", represents the grand total of all charges billed. Sum column 53 on the adjacent line. Each line allows up to eight numeric digits (000000.00).

Items 54, 55, and 56. Unlabeled Charge Columns
Not required.

Items 57A, B, C. Payer Identification
If Medicare is the primary payer, enter "Medicare" on line A. All additional entries across line A (items 58-64) supply information needed by the payer named in item 57A. If Medicare is the secondary or tertiary payer, identify the primary payer on line A and enter Medicare information on line B or C as appropriate. See §§248, 250, 251, 252, and 253 to determine when Medicare is not the primary payer.

Items 58A, B, C. Release of Information Certification Indicator
Not Required. Note: The back of the UB-82 contains an agency certification that all necessary release statements are on file.

Items 59A, B, C. Assignment of Benefits Certification Indicator
Not Required.

Items 60A, B, C. Deductible
Not required. (For services rendered April 1, 1985, and later.) Note: Effective with services rendered April 1, 1985, and later, amounts collected from the patient toward the Part B cash deductible are no longer reported in this item, but rather are reported on the fourth line of item 63. Such amounts may only be reported on bills containing "4" in the second position of item 4, Type of Bill.

Items 61A, B, C. Coinsurance
Not required. (For services rendered April 1, 1985, and later.) Note: Effective with services rendered April 1, 1985, and later, amounts collected from the patient toward Part A cost sharing for DME ("3" in the second position of item 4, Type of Bill and revenue code(s) in the 29X series entered in item 51) or toward Part B coinsurance ("4" in the second position of item 4, Type of Bill) are reported on the fourth line of item 63.

Item 62A, B, C. Estimated Responsibility
Not Required.

Items 63A, B, C. Prior Payments
For services rendered April 1, 1985, and later, enter on the unnumbered (fourth/last) line of this column the sum of any amount(s) collected from the patient toward:

1. Cost sharing for Part A DME ("3" in second position of item 4, Type of Bill and revenue code(s) in 29X series in item 51), and

2. Part B cash deductible and/or coinsurance for services rendered which are not under a plan of treatment ("4" in second position of item 4, Type of Bill).

Items 64A, B, C. Estimated Amount Due
Not Required.

Items 65A, B, C. Insured's Name
On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in items 57-63, enter the patient's name as shown on his HI card or other Medicare notice.

If there are payer(s) of higher priority than Medicare and you are requesting payment because another payer paid some of the charges and Medicare is secondarily liable for the remainder, or you are requesting conditional payment as described in §§494G, 495F, 496F, or 497F, enter the name of the individual in whose name the insurance is carried. If that person is the patient, enter "Patient." Payers of higher priority than Medicare include:

1. EGHPs for employed beneficiaries and their spouses age 65 to 69 (see §251); or

2. EGHPs for beneficiaries entitled to benefits solely on the basis of ESRD during a period up to 12 months (see §252); or

3. An auto-medical, no-fault, or liability insurer (see §251); or

4. WC including BL (see §250).

Items 66A, B, C. Insured's Sex
If claiming payment under any of the circumstances described under items 65A, B, or C enter the sex of the insured. Use the following codes:

M=Male
F=Female

Items 67A, B, C. Patient's Relationship To Insured
If claiming payment under any of the circumstances described under items 65A, B, or C enter the code indicating the relationship of the patient to the identified insured.

Code	Title	Definition
01	Patient is the Insured	Self-explanatory
02	Spouse	Self-explanatory
03	Natural Child/Insured Financial Responsibility	Self-explanatory
04	Natural Child/Insured does not have Financial Responsibility	Self-explanatory
05	Step Child	Self-explantory
06	Foster Child	Self-explanatory
08	Employee	Patient is employed by the insured.
09	Unknown	Patient's relationship to the insured is unknown.
15	Injured Plantiff	Patient is claiming insurance as a result of injury covered by insured.

Items 68A, B, C. Certificate/Social Security Number/HI Claim/Identification Number
On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information was shown in items 57-63, enter the patient's Medicare health insurance claim number; i.e., if Medicare is the primary payer, enter this information in item 68A. Show the number as it appears on the patient's HI Card, Certificate of Award, Utilization Notice, Explanation of Medicare Benefits, Temporary Eligibility Notice, or as reported by the Social Security Office.

If claiming a conditional payment under any of the circumstances described under items 65A, B, or C enter the involved claim number for that coverage on the appropriate line.

Items 69 A, B, C. Group Name
Where you are claiming a payment under the circumstances described in items 65 A, B, or C and there is involvement of WC or an EGHP, enter the name of the group or plan through which that insurance is provided.

Items 70 A, B, C. Insurance Group Number
Where you are claiming a payment under the circumstances described under items 69 A, B, or C and there is involvement of WC or an EGHP, enter the identification number, control number or code assigned by such health insurance carrier to identify the group under which the insured individual is covered.

GUIDELINES FOR EMPLOYMENT INFORMATION

The following items are grouped together for ease in supplying instructions on their completion: 71, 72, 73, 74, 75. Space is reserved for reporting the necessary employment data for up to two individuals. Use the following sequence of decision-making in completing these fields.

INDIVIDUALS CLAIMING INSURANCE

1. If any of the insureds named under A, B, or C in the insurance section of the form (item 65) has group insurance provided by an organization other than the employer, enter the insured's employment information and code EID (item 71) A, B, or C depending upon the payer line the individual's insurance information is recorded on; (e.g., item 69 records Group Name as Washington Area Ford Dealers, Inc. but the insured's employer is Capital Ford, Inc. Because the insurance is held with a company other than the employer, the employer information is required for the insured.)

2. If any of the individuals recorded under A, B, or C in this insurance section of the form (item 65) has group insurance coverage provided by an employer who operates from multiple locations, enter employment information (and location) and EID (item 71) A, B, or C depending upon the payer line the individual insurance information is recorded on.

Item 71. Employment Information Data
Where you are claiming a payment under the circumstances described under items 69 A, B, or C and there is involvement of WC or an EGHP, enter the code that indicates whether the employment information given on the same line in items 72-75 applies to the insured, the patient or the patient's spouse.

Use either the "A, B, C" codes or the "P, S, F, M" codes, in this item, depending on which set best handles the billing situation.

Code Structure

A = Employment Information relates to primary insured.
B = Employment Information relates to secondary insured.
C = Employment Information relates to tertiary insured.
P = Patient Employment Information
S = Spouse Employment Information
F = Father's Employment Information
M = Mother's Employment Information

NOTE: When there is a single employer, enter only one code from the code structure. When the employment information pertains to multiple payers from item 57, enter two codes from the code structure.

Item 72. Employment Status Code
Where you are claiming a payment under the circumstances described under items 69A, B, or C, and there is involvement of WC or an EGHP, enter the code which defines the employment status of the individual identified on the same line in item 71, if the information is readily available.

Code	Title	Definition
1	Employed full time	Individual states that he or she is employed full time.
2	Employed part time	Individual states that he or she is employed part time.

Item 73. Employer Name
Where you are claiming a payment under the circumstances described under items 69A, B, or C, and there is involvement of WC or an EGHP, enter the name of the employer that provides health care coverage for the individual identified on the same line in item 71.

Item 74. Employee Identification Number
Where you are claiming a payment under the circumstances described under items 69A, B, or C, and there is involvement of WC or an EGHP, enter the identification number assigned by the employer to the individual identified on the same line in item 71.

Item 75. Employer Location
Where you are claiming a payment under the circumstances described under items 69A, B, or C and there is involvement of WC or an EGHP, enter the specific location of the employer of the individual identified on the same line in item 71. A specific location is the city, plant, etc. in which the employer is located.

Item 76. Principal and Other Diagnoses Descriptions
Not required.

Item 77. Principal Diagnosis Code
Report the principal diagnosis or diagnosis most related to the plan of treatment, according to the attending physician, in this item. Report the full ICD-9-CM diagnosis code, including all five digit codes where applicable.

Items 78-81. Other Diagnoses Codes
Enter the ICD-9-CM codes for up to four additional diagnoses for conditions coexisting according to the attending physician.

Item 82. Procedure Coding Method Used
Not required.

Item 83. Principal and Other Procedures Descriptions
Not required.

Item 84. Principal Procedure Code and Date
Not required.

Item 85 and 86. Other Procedure Codes and Dates
Not required.

Item 87. PSRO/UR Approval Indicator
Not required.

Item 88 and 89. PSRO/UR Approved Stay Dates
Not required.

Item 90. Number of Grace Days
Not required.

Item 91. Treatment Authorization Code
Not required.

Item 92. Attending Physician I.D.
Not required.

Item 93. Other Physician I.D.
Not required.

Item 94. Remarks
Enter special annotations where Medicare is not the primary payer because WC, automobile medical, no-fault, liability, or an EGHP is primary to Medicare. (See SS494, 495, 496, and 497 for appropriate annotations.) In addition, enter any remarks needed to provide information that is not shown elsewhere on the bill but which is necessary for proper payment.

Provider Representative Signature and Date
Make sure that the required physician's certification is in the records before signing the form. A stamped signature is acceptable.

Intermediary Use Only Area.
Not Required.

Example 1

MEDICARE
HOME HEALTH
REGULAR BILLING

This homebound patient is receiving skilled nurse and home health aide visits for his illness. The physician established the home health plan on February 8, 1983, and the home health agency started care on February 8, 1983. This home health agency is billing for services for the month of December 1983 and expects to continue rendering these services in January 1984.

POUDRE VALLEY VNA
161 MAIN STREET
FT. COLLINS, CO 80521

3 PATIENT CONTROL NUMBER

332

7 MEDICARE NO: 067999

10 PATIENT'S LAST NAME: BREWER
FIRST NAME: WALT
11 PATIENT'S ADDRESS: 316 EAST STREET
CITY: FT. COLLINS
STATE: CO
ZIP: 80521

BIRTH DATE	SEX	ADMISSION DATE	STAT	STATEMENT COVERS PERIOD FROM	THROUGH
01-25-01	M	2-9-83	30	12-01-83	12-31-83

OCCURRENCE
CD	DATE
27	02-08-83

DESCRIPTION	51 R. CODE	52 S. UNITS	53 TOTAL CHARGES	
SKILLED NURSING CARE	552	4	154	00
HOME HEALTH AIDE	571	10	330	00
	001	14	484	00

57 PAYER
A MEDICARE
B
C

DEDUCTIBLE | 61 COINSURANCE | 62 EST. RESPONSIBILITY | 63 PRIOR PAYMENTS

DUE FROM PATIENT ▶

INSURED'S NAME
A BREWER, WALT
B
C

CERT.-SSN-HIC-ID NO: 574-22-1668 A

69 GROUP NAME | 70 INSURANCE GROUP NO.

71 | 72 | 73 EMPLOYER NAME | 74 EMPLOYEE ID | 75 EMPLOYER LOCATION

76 PRINCIPAL AND OTHER DIAGNOSES DESCRIPTIONS

77 PRIN. CODE: 486

OTHER DIAGNOSES CODES: 401.9 | 715.90

PRINCIPAL AND OTHER PROCEDURES DESCRIPTIONS

PRINCIPAL PROCEDURE CD | DATE | CC | DATE | CC | DATE

91 TREATMENT AUTH.

92 ATTENDING PHYSICIAN ID: DONALD JANUARY, M.D.

93 OTHER PHYSICIAN ID: DR. BLACK

94 REMARKS

PATIENT IS HOMEBOUND

VERIFIED NC STAY DATES FROM | THROUGH

AMT. REIMBURSED | APPROV. BY | DATE APPRV.

I CERTIFY THAT THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

PROVIDER REPRESENTATIVE X

DATE

UB-82 HCFA-1450

PAYER COPY

EXAMPLE 2

HOME HEALTH

This example represents a billing for home health aide services provided to Janet Smith, who is covered by Blue Cross and Blue Shield of Colorado.

NOTE: Part of the form locators shown as completed on the claim form are required by commercial payers and are shown for your information only.

XYZ HOME HEALTH AGENCY
700 MAIN STREET
ANYTOWN, CO 80125

54321

331

499

84-136245

SMITH JANE W 451 BROADWAY DENVER COLORADO 80204

06-05-45 F M 5-1-84 6-1-84 6-22-84

DARYL L. SMITH
451 BROADWAY
DENVER, CO 80204

DESCRIPTION	REV. CODE	UNITS	TOTAL CHARGES	
PHYSICAL THERAPY	420	3	45	00
SKILLED NURSING CARE	550	10	300	00
HOME HEALTH AIDE	570	4	60	00
	001	17	405	00

BCBS OF COLORADO 050

DUE FROM PATIENT ▶

SMITH, DARYL L. 02 311-12-4567 00005

S 1 BC PLUMBING 511124567 37 - ACOMA, DENVER, CO 80204

808.8

PROVIDER REPRESENTATIVE X

UB-82 HCFA-1450

PAYER COPY

Item 72. Employment Status Code
Where claiming a conditional payment under the circumstances described under items 69A, B, or C, enter the code which defines the employment status of the individual identified on the same line in item 71, if the information is readily available.

Code	Title	Definition
1	Employed full time	Individual states that he or she is employed full time.
2	Employed part time	Individual states that he or she is employed part time.

Item 73. Employer Name
Where claiming a conditional payment under the circumstances described under items 69A, B, or C, enter the name of the employer that provides health care coverage for the individual identified on the same line in item 71.

Item 74. Employee Identification Number
Where claiming a conditional payment under the circumstances described under items 69A, B, or C, enter the identification number assigned by the employer to the individual identified on the same line in item 71.

Item 75. Employer Location
Where claiming a conditional payment under the circumstances described under items 69A, B, or C, enter the specific location of the employer of the individual identified on the same line in item 71. A specific location is the city, plant, etc. in which the employer is located.

Item 76. Principal and Other Diagnoses Descriptions
Not required.

Item 77. Principal Diagnosis Code
Report the principal diagnosis or diagnosis most related to the plan of treatment, according to the attending physician, in this item. Report the full ICD-9-CM diagnosis code, including all five digit codes where applicable.

Items 78-81. Other Diagnoses Codes
Enter the ICD-9-CM codes for up to four additional diagnoses for conditions co-existing according to the attending physician.

Item 82. Procedure Coding Method Used
Not required.

Item 83. Principal and Other Procedures Descriptions
Not required.

Item 84. Principal Procedure Code and Date
Not required.

Item 85 and 86. Other Procedure Codes and Dates
Not required.

Item 87. PSRO/UR Approval Indicator
Not required.

Item 88 and 89. PSRO/UR Approved Stay Dates
Not required.

Item 90. Number of Grace Days
Not required.

Item 91. Treatment Authorization Code
Not required.

Item 92. Attending Physician I.D.
Not required.

Item 93. Other Physician I.D.
Not required.

Item 94. Remarks
Enter any remarks needed to provide information that is not shown elsewhere on the bill but which is necessary for proper payment.

When equipment has been sold to a beneficiary, enter "medical necessity (no.) months." This certifies that a physician's prescription indicates the required period of medical necessity for the equipment.

Provider Representative Signature and Date
Make sure that the required physician's certification is in the records before signing the form. A stamped signature is acceptable.

Intermediary Use Only Area.
Not Required.

Retention and Destruction of Health Insurance Records

480. RETENTION OF HEALTH INSURANCE RECORDS.

The several categories of health insurance materials related to services rendered under title XVIII should be maintained for the pescribed retention periods outlined below unless State law stipulates a longer period of retention. They should be made available for reference to SSA, intermediary, DHEW Audit or other specially designated components for bill review, audit, and other references during the retention period.

A. Categories of Health Insurance Records to Be Retained.--If these records are microfilmed, also see C below.

1. Billing Material.--Home health agency copies of forms SSA-1483, SSA-1487, and any other SSA billing forms, supporting documents and forms, charge slips, and other business and accounting records referring to specific claims.

2. Cost Report Material.--All data necessary to support the accuracy of the entries on the annual cost reports, including original invoices, cancelled checks, home health agency copies of material used in preparing annual cost reports, schedules and related work sheets), and contracts or records of dealings with outside sources of medical supplies and services or with related organizations.

3. Medical Record Material.--Physicians' certifications and recertifications, clinical and other medical records relating to health insurance claims.

4. Home Health Agency Physician Material.--Home health agency physician agreements on which Part A-Part B allocations are based.

B. Retention Period for Health Insurance Records.--Retain all of the materials referred to in items 1 through 4 above for a period of 5 years after the month the cost report to which the materials apply is filed with the intermediary.

EXAMPLE: Billing materials support claims filed during a cost report period ending 10/31/74. The HHA cost report for the period ending 10/31/74 was filed with the intermediary on 1/15/75. All billing materials must be retained until 2/1/80.

After payment of the bill, the home health agency need not retain administrative and billing work records provided that, and only to the extent that, such material does not represent critical detail in support of summaries related to the records outlined in A above. These records include punch cards, adding machine tapes, internal controls, or other similar material not required for record retention.

C. Microfilming Health Insurance Records.--A home health agency may at its option microfilm all health insurance records.

1. Billing material (Forms SSA-1487, SSA-1483, etc.) with any attachments that the home health agency has furnished to its intermediary may be destroyed providing the microfilm accurately reproduces all the original documents.

2. Copies of all other categories of health insurance records listed in § 480A must be retained in their original form. If a home health agency microfilms these records, it should store these records in a low cost facility for the retention period.

480.1 Destruction of Health Insurance Records.--When material need no longer be retained for title XVIII purposes, it may be destroyed by the agency unless State law stipulates a longer period of retention.

In order to insure the confidentiality of the records, it is requested that they be destroyed by shredding, mutilation or other protective measures. The method of final disposition of the records may provide for their sale as salvage. Monies received should be reported as an adjustment to expense in the cost report for the year sold.

OVERPAYMENTS

490. OVERPAYMENTS FOR HHA SERVICES - GENERAL

When an incorrect Medicare payment is made to an HHA it is responsible for that payment unless the intermediary determines that it was without fault. In general, if an overpaid HHA was without fault and therefore not liable for the overpayment, the beneficiary becomes liable whether or not the beneficiary was at fault. There are, however, exceptions to this rule. In the case of overpayments for medically unnecessary services or custodial care, if the beneficiary as well as the HHA was without fault, the intermediary may relieve both of liability. (See § 260ff.) Under certain circumstances, the Medicare Bureau or the Social Security Administration may waive recovery from a beneficiary who is responsible for an overpayment. (See § 492.)

NOTE: A payment on an individual claim will not be reopened more than 48 months after the date the claim was approved except in cases involving fraud or similar fault. (See § 258.)

491. WHEN AN HHA IS NOT LIABLE FOR AN OVERPAYMENT

An HHA is considered without fault, and therefore not liable for refunding an overpayment, if it exercised reasonable care in billing for and accepting the payment.

(1) It complied with all pertinent regulations and instructional materials:

(2) It made full disclosure of all material facts, and

(3) On the basis of the information available, including but not limited to the Medicare instructions and regulations, it had a reasonable basis for assuming that the payment was correct, or, if it had reason to question the payment, it promptly brought such questions to the intermediary's attention.

The above criteria would be met if an overpayment was made to an HHA on behalf of an individual who was not entitled to Medicare benefits or if SSA or the carrier mistakenly paid an HHA a deductible amount. (See § 491.1C.)

Normally, it is clear from the circumstances of the overpayment whether or not the HHA was without fault in causing the overpayment. Where this is not clear from the record, the intermediary investigates the matter. (See § 493 for special rule where the overpayment is discovered more than 3 calendar years after the year in which it was made.)

491.1 Situations in Which HHA Is Liable for Overpayment.--In accordance with the rules in § 491 above, the following are situations in which the HHA is liable for an overpayment:

A. The HHA furnished erroneous information or failed to disclose facts that it knew or should have known were relevant to payment of the benefit.--

EXAMPLE: A beneficiary is referred by an employer to a hospital for a fracture received from a fall at work. After he was released from the hospital he was furnished home health services by the Community HHA. The services met all coverage requirements except that there was a possibility they were covered by workers' compensation. The Community HHA billed Medicare but did not indicate on the billing form that the injury was work-related, although it had been told by the hospital that the injury was work-related and had recorded this information on its records. If Medicare benefits are paid for the visits and the injury was also covered by workers' compensation, the Community HHA would be considered at fault in causing the overpayment because it failed to disclose to the intermediary that the injury was work-related.

B. The overpayment was due to a mathematical or clerical error, e.g., an error in calculation by the HHA or intermediary, or overlapping or duplicate bills. A mathematical error does not include the failure to properly assess the SMI deductible.

C. Documentation was not submitted to substantiate that the services billed to the program were actually performed. (See §§ 106ff. for fraud and abuse policies.)

D. The beneficiary was not entitled to Part A or Part B benefits and the HHA had reason to believe that the beneficiary was not entitled to such benefits, e.g., the social security office notified the HHA that the individual was not entitled to hospital or medical insurance benefits.

E. Medicare paid for noncovered services and the HHA should have known the services were noncovered; e.g., medically unnecessary services, custodial care, skilled physical therapy services furnished by a non-qualified physical therapist, or services rendered pursuant to an authorization from the VA or PHS. (See § 232.3.) In general, the intermediary will consider that the HHA should have known a policy or rule, if

1. The policy or rule is in the HHA Manual, or

2. The intermediary had provided general notice to the medical community concerning the policy or rule, or

3. The intermediary had given written notice of the policy or rule to the particular HHA.

In the case of medically unnecessary services or custodial care, the criteria in §§ 260ff. will be applied in determining whether the HHA should have known that the services were not covered.

492. BENEFICIARY LIABILITY

A beneficiary is liable for overpayments made to a HHA which was without fault, with the exception of overpayments for medically unnecessary services or custodial care where the beneficiary as well as the provider was without fault. In such cases, both the HHA and the beneficiary are relieved of liability. (See §§ 260ff.)

NOTE: Even though a beneficiary is liable for an overpayment, recovery may be waived by the Medicare Bureau or the SSA program service center if (1) the beneficiary was without fault with respect to the overpayment, and (2) recovery of the overpayment would cause the beneficiary economic hardship or would defeat the purpose of the Medicare Program, or would be unfair for some other reason.

493. LIABILITY FOR OVERPAYMENTS DISCOVERED SUBSEQUENT TO THIRD CALENDAR YEAR AFTER THE YEAR OF PAYMENT

Special rules apply when an overpayment is discovered (i.e., it is determined that a payment was incorrect) subsequent to the third calendar year after the year in which the claim was approved. An overpaid HHA is deemed without fault in the absence of evidence to the contrary if from the records then available, there is no indication that the HHA was at fault. There is no recovery from the HHA in such cases.

However, if information indicating the HHA was at fault comes to the intermediary's attention within 48 months after the date of the initial determination (the 4-year time limit on reopening described in § 258) then the determination may be revised. After 4 years, the determination may be reopened only in cases involving fraud or similar fault.

A. Limitations on Charging Without Fault Beneficiary Where Overpayment for Medically Unnecessary Services or Custodial Care Discovered Subsequent to Third Calendar Year.--Where an overpayment for medically unnecessary services or custodial care is discovered subsequent to the third calendar year after the year in which it was made, the HHA is prohibited from charging the beneficiary or any other person for the services if: (1) the HHA was at fault with respect to the overpayment, and (2) the beneficiary was without fault with respect to the overpayment. (Where the overpayment is discovered in or before the third calendar year, an "at fault" HHA is not prohibited from charging the beneficiary for medically unnecessary services or custodial care if it has refunded the overpayment. However, a without fault beneficiary who pays an at fault HHA's bill for medically unnecessary services or custodial care furnished after 10/30/72, can be indemnified in accordance with §§ 269ff.)

B. How to Determine the Third Calendar Year After the Year of Payment.--Only the year the claim was approved and the year the payment was found to be incorrect enter into the determination of the 3-calendar year period. The day and the month are irrelevant. With respect to claims approved in 1975, the third calendar year is 1978. For claims approved in 1976, the third calendar year is 1979, etc. Thus, the rules in this section would apply to claims approved in 1975 and discovered after 1978 to have been incorrectly paid and to claims approved in 1976 and discovered after 1979, to have been incorrectly paid.

Billing in Situations Where Medicare Secondary Payer

494. BILL PREPARATION WHERE SERVICES ARE REIMBURSABLE UNDER WORKERS' COMPENSATION

A. General.—Payment may not be made under Medicare for any items or services to the extent that payment has been made, or can reasonably be expected to be made for such items or services under a workers' compensation law or plan of the United States or a State. For an explanation of these provisions see §250.

Expenses for services for which Medicare payment may not be made because of these provisions are not counted toward the Part B deductible amount.

Annotate all bills, with the exception of the HCFA-1450, where Medicare is determined to be primary payer with the statement "Medicare Primary Payer" in the blank space under item 22C when billing on the HCFA-1487 or in "Remarks" when billing on the HCFA-1483. On the HCFA-1450, show Medicare on line A of item 57. Where Medicare is secondary, show Medicare on line B of item 57. In addition, when you are billing Medicare because the workers' compensation plan denied payment, enter occurrence code 24 (insurance denied) and the date of denial in items 28-32 (occurrence codes) on the HCFA-1450. Enter the reason for the denial in remarks (item 94). On the HCFA-1483 or HCFA-1487, annotate remarks with the statement "WC: Denied" and provide the reason for denial. Prepare all bills where Medicare is not primary payer because of these provisions in accordance with the following instructions. In applying the guidelines, it may be necessary to determine the current Medicare interim reimbursement amount (without regard to deductible or coinsurance). See §498 for instructions to determine this amount.

B. Outpatient Bills (HCFA-1450 or HCFA-1483) - Full Payment by Workers' Compensation.—If the payment from the workers' compensation plan equals or exceeds your charges or the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) or you are otherwise required under the workers' compensation law to accept the payment as payment in full, do not submit a bill.

C. Outpatient Bills (HCFA-1450 or HCFA-1483) - Partial Payment by Workers' Compensation.—If the payment from the workers' compensation plan is less than your charges and the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) and you are not required under the workers' compensation law to accept the payment as payment in full, prepare Form HCFA-1450 or HCFA-1483 in accordance with §460 or §475 with the following modifications:

1. Determining covered charges

Show in the covered charges column, Medicare covered charges including those covered by the workers' compensation plan's payment.

2. Determining amount of primary payer payment that applies to the Medicare covered services

Where you can determine the primary payer's allocation of its payment between covered and noncovered Medicare services, indicate the amount paid by the primary payer toward Medicare covered services in value codes (items 46-49) on the HCFA-1450 or in "Remarks" on the HCFA-1483. Where you can not determine the services covered by the primary payment, apply a ratio of Medicare covered charges to total charges for the services to the primary payment amount to determine the portion attributable to Medicare covered services and indicate this amount in value codes (items 46-49) on the HCFA-1450 or "Remarks" on the HCFA-1483. You must be able to validate your ratio of covered and noncovered charges if requested.

EXAMPLE:

Total charges were $200. Medicare covered charges were $180. The workers' compensation plan's payment was $55. Since you cannot determine the allocation of the primary payer's payment, determine the allocation as follows:

$$\frac{\$180}{\$200} \times \$55 = \$50$$

Show $50 in value codes (items 46-49) on the HCFA-1450 or "Remarks" on the HCFA-1483.

3. Determining the amount of Medicare payment

Subtract the payment by the workers' compensation plan for Medicare covered services from the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) per §498 and apply any applicable deductible and/or coinsurance to the remainder.

EXAMPLE 1:

Outpatient care was furnished to a Medicare beneficiary whose workers' compensation plan was primary payer. The charges for the services were $180. No part of the beneficiary's Part B deductible had been met previously. The workers' compensation plan paid $50 for Medicare covered services as determined in item 2 above. The Medicare interim reimbursement (without regard to deductible or coinsurance) for these services at 90 percent of charges would be $162. The deductible and coinsurance are calculated as follows:

The deductible is determined as the lesser of (1) $75 or (2) the total covered charges for Medicare services less the primary payer's payment for Medicare covered services; in this case: $180 (charges) - $50 (primary payer's payment) = $130 which exceeds $75. The Part B deductible amount you can charge to the beneficiary is $75.

The coinsurance is calculated as the charges minus the primary payer's payment minus the deductible times 20 percent. $180 (charges) - $50 (primary payer's payment) = $130 (charges subject to deductible and coinsurance) - $75 (deductible) = $55 X 20 percent = $11 coinsurance.

As secondary payer, Medicare pays the following: the Medicare interim reimbursement minus the workers' compensation plan's payment for Medicare covered services minus the deductible and coinsurance: $162 - $50 - $75 - $11 = $26. Medicare pays $26 as secondary payer.

EXAMPLE 2:

Same facts as in Example 1 above except the covered charges were $100, the primary payer's payment was $60 and the Medicare interim reimbursement (without regard to deductible or coinsurance) for the services at 90 percent of charges was $90. The deductible and coinsurance are calculated as follows:

The deductible is determined as the lesser of (1) $75 or (2) the total covered charges for Medicare services less the primary payer's payment for Medicare covered services, in this case: $100 (charges) - $60 (primary payer's payment) =$40. Since $40 is less than $75, the Part B deductible amount you can charge to the beneficiary is $40.

Since the $75 Part B deductible is not met there is no coinsurance amount and there is no Medicare payment. The patient's liability is $40 of the $75 deductible.

4. Special entries on the bill

On Form HCFA-1450, show the identifying information in items 57-68 on the first payer line, occurrence code 04 and the associated date in items 28-32, condition code 02 in items 35-39, value code 15 with the amount paid in value codes (items 46-49), and the address of the workers' compensation plan in item 34 or remarks (item 94).

On Form HCFA-1483, show the name and address of the workers' compensation plan and the amount paid by the workers' compensation plan for Medicare covered services with the statement "WC (amount)" in "Remarks." In addition, enter the policy and or identification number.

D. Home Health Agency Bills (HCFA-1450 or HCFA-1487) - Full Payment by Workers' Compensation.--If the payment from the workers' compensation plan equals or exceeds your charges or the current Medicare interim reimbursement amount or you are otherwise required under the workers' compensation law to accept the payment as payment in full, do not submit a bill.

E. Home Health Agency Bills (HCFA-1450 or HCFA-1487) - Partial Payment by Workers' Compensation.--If the payment from the workers' compensation plan is less than your charges and the current Medicare interim reimbursement amount, and you are not required under the workers' compensation law to accept the payment as payment in full, prepare Form HCFA-1450 or HCFA-1487 in accordance with §420 or §475 with the following modifications:

1. Determining charges and visits

Show in the charges and visits columns of the bill Medicare covered charges and visits including those covered by the workers' compensation plan's payment.

2. Determining amount of primary payer payment that applies to the Medicare covered services

Where you can determine the primary payer's allocation of its payment between covered and noncovered Medicare services, indicate the amount paid by the primary payer toward Medicare covered services in value codes (items 46-49) on the HCFA-1450 or in the blank space under item 22C on the HCFA-1487. Where you can not determine the services covered by the primary payment, apply a ratio of Medicare covered charges to total charges for the services to the primary payment amount to determine the portion attributable to Medicare covered services and indicate this amount in value codes (items 46-49) on the HCFA-1450 or in the blank space under item 22C on the HCFA-1487. You must be able to validate your ratio of covered and noncovered charges if so requested.

EXAMPLE:

Total charges were \$550. Medicare covered charges were \$500. The workers' compensation plan's payment was \$330. Since you cannot determine the allocation of the primary payer's payment, determine the allocation as follows:

$$\frac{\$500}{\$550} \times \$330 = \$300$$

Show \$300 in value codes (items 46-49) on the HCFA-1450 or in the blank space under item 22C on the HCFA-1487.

3. Determining the amount of Medicare payment

Subtract the payment by the workers' compensation plan for Medicare covered services from the current Medicare interim reimbursement amount.

NOTE: There is no deductible or coinsurance applicable under Part A and B HHA services billed on a HCFA-1450 or HCFA-1487.

EXAMPLE 1: Per Visit Method

A beneficiary received 10 visits for which the current Medicare interim reimbursment amount at \$50 per visit interim rate was \$500. The workers' compensation plan paid \$300 for Medicare covered services as determined in item 2 above. As secondary payer Medicare pays the following:

The Medicare interim reimbursement minus the workers' compensation plan's payment for Medicare covered services: \$500 - \$300 = \$200. Medicare pays \$200 as secondary payer.

EXAMPLE 2: Percentage of Billed Charges Method

A beneficiary received 10 visits at $50 per visit. The Medicare interim rate was 90 percent ($500 X 90 percent) which equaled $450. The workers' compensation plan paid $300 for Medicare covered services as determined in item 2 above. As secondary payer Medicare pays the following:

The Medicare interim reimbursement minus the workers' compensation plan's payment for Medicare covered services: $450 - $300 - $150. Medicare pays $150 as secondary payer.

4. Special entries on the bill

On Form HCFA-1450, show the identifying information in items 57-68 on the first payer line, occurrence code 04 and the associated in items 28-32, condition code 02 in items 35-39, value code 15 with the amount paid in value codes (items 46-49), and the address of the workers' compensation plan in item 34 or remarks (item 94).

On Form HCFA-1487, show the name and address of the workers' compensation plan and the amount paid by the workers' compensation plan for Medicare covered services with the statement "WC (amount)" in the blank space under item 22C. In addition, enter the policy and or identification number.

F. Conditional Payments.—Conditional Medicare benefits may be paid while a workers' compensation claim is contested. Where a claim is contested, bill Medicare as usual. On Form HCFA-1450, request conditional payment by showing occurrence code 04 and the associated date in items 28-32 occurrence codes and condition code 02 in items 35-39. Show value code 15 with zero value in items (46-49) to indicate the type of other insurer and that conditional payment is requested. Identify the other payer on line A of item 57, and enter on line A of items 65-68 other identifying information about the insured. Enter the address of the workers' compensation plan in item 34 or remarks (item 94). In addition, provide an explanation of why the conditional payment is justified in remarks (item 94).

On Forms HCFA-1483 and HCFA-1487, annotate "Remarks" with the statement "W.C.: Requesting conditional Medicare benefits." In addition, show the name and address of the workers' compensation plan, the policy and/or identification number and provide an explanation of why the conditional payment is justified.

495. BILL PREPARATION WHERE SERVICES ARE REIMBURSABLE UNDER AUTOMOBILE MEDICAL, NO-FAULT, OR ANY LIABILITY INSURANCE

A. General.—Payment may not be made under Medicare for otherwise covered items or services to the extent that payment has been made, or can reasonably be expected to be made, for the items or services under automobile medical, no-fault insurance, or any liability insurance. For an explanation of these provisions see §§248 and 251.

Expenses for services for which Medicare payment may not be made because of these provisions are not counted toward the Part B deductible amount.

Annotate all bills with the exception of the HCFA-1450, where Medicare is determined to be primary payer with the statement "Medicare Primary Payer" in the blank space under item 22 C when billing on the HCFA-1487 or in "Remarks" when billing on the HCFA-1483. On the HCFA-1450, show Medicare on line A of item 57. Where Medicare is secondary, show Medicare on line B of item 57. Prepare all bills where Medicare is not primary payer because of these provisions in accordance with the following instructions. In applying the guidelines, it may be necessary to determine the current Medicare interim reimbursement amount (without regard to deductible or coinsurance). See §498 for instructions to determine this amount.

B. Outpatient Bills (HCFA-1450 or HCFA-1483) - Full Payment by Automobile Medical, No-Fault, or Liability Insurance.—If the payment from the automobile medical, no-fault, or liability insurer equals or exceeds your charges or the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) or you are obligated to accept the payment as payment in full, do not submit a bill.

C. Outpatient Bills (HCFA-1450 or HCFA-1483) - Partial Payment by Automobile Medical, No-Fault, or Liability Insurance.—If payment from the automobile medical, no-fault, or liability insurer is less than your charges and the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) and you are not obligated to accept the payment as payment in full, prepare Form HCFA-1450 or HCFA-1483 in accordance with §460 or §475 with the following modifications:

1. Determining covered charges

Show in the covered charges column, Medicare covered charges including those covered by the automobile medical, no-fault, or liability insurer's payment.

2. Determining amount of primary payment that applies to Medicare covered services

Where you can determine the primary payer's allocation of its payment between covered and noncovered Medicare services, indicate the amount paid by the primary payer toward Medicare covered services in value codes (items 46-49) on the HCFA-1450 or in "Remarks" on the HCFA-1483. Where you cannot determine the services covered by the primary payment, apply a ratio of Medicare covered charges to total charges for the services to the primary payment amount to determine the portion attributable to Medicare covered services and indicate this amount in value codes (items 46-49) on the HCFA-1450 or "Remarks" on the HCFA-1483. You must be able to validate your ratio of covered and noncovered charges, if requested.

EXAMPLE:

Total charges were $200. Medicare covered charges were $180. The automobile medical insurer's payment was $55. Since you cannot determine the allocation of the primary payer's payment, determine the allocation as follows:

$$\frac{\$180}{\$200} \times \$55 = \$50$$

Show $50 in value codes (items 46-49) on the HCFA-1450 or "Remarks" on the HCFA-1483.

3. Determining the amount of Medicare payment

Subtract the payment by the automobile medical, no-fault, or liability insurer for Medicare covered services from the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) per §498 and apply any applicable deductible and/or coinsurance to the remainder.

EXAMPLE 1:

Outpatient care was furnished to a Medicare beneficiary whose automobile medical insurer was the primary payer. The charges for the services were $180. No part of the beneficiary's Part B deductible had been met previously. The automobile medical insurer paid $50 for Medicare covered services as determined in item 2 above. The Medicare interim reimbursement (without regard to deductible or coinsurance) for these services at 90 percent of charges would be $162. The deductible and coinsurance are calculated as follows:

The deductible is determined as the lesser of (1) $75 or (2) the total covered charges for Medicare services less the primary payer's payment for Medicare covered services; in this case: $180 (charges) - $50 (primary payer's payment) = $130 which exceeds $75. The Part B deductible amount you can charge to the beneficiary is $75.

The coinsurance is calculated as the charges minus the primary payer's payment minus the deductible times 20 percent. $180 (charges) - $50 (primary payer's payment) = $130 (charges subject to deductible and coinsurance) - $75 (deductible) = $55 X 20 percent = $11 coinsurance.

As secondary payer, Medicare pays the following: the Medicare interim reimbursement minus the automobile medical insurer's payment for Medicare covered services minus the deductible and coinsurance: $162 - $50 - $75 - $11 = $26. Medicare pays $26 as secondary payer.

EXAMPLE 2:

Same facts as in Example 1 above except the covered charges were $100, the primary payer's payment was $60 and the Medicare interim reimbursement (without regard to deductible or coinsurance) for the services at 90 percent of charges was $90. The deductible and coinsurance are calculated as follows:

The deductible is determined as the lesser of (1) $75 or (2) the total covered charges for Medicare services less the primary payer's payment or Medicare covered services, in this case: $100 (charges) - $60 (primary payer's payment) = $40. Since $40 is less than $75, the Part B deductible amount you can charge to the beneficiary is $40.

Since the $75 Part B deductible is not met there is no coinsurance amount and there is no Medicare payment. The patient's liability is $40 of the $75 deductible.

4. Special entries on the bill

On Form HCFA-1450, show the identifying information in items 57-68 on the first payer line, occurrence code 01, 02, or 03 as appropriate and the associated date in items 28-32, value code 14 with the amount paid in value codes (items 46-49) and the address of the automobile medical, no-fault insurer, or any liability insurer in item 34 or remarks (item 94).

On Form HCFA-1483, show the name and address of the automobile medical, no-fault insurer, or the liability insurer and the amount paid by the automobile medical, no-fault insurer, or the liability insurer for Medicare covered services with a statement such as "XYZ Company (amount)" in "Remarks." In addition, enter the policy number and indicate "automobile accident" or "non-automobile accident" as appropriate.

D. Home Health Agency Bills (HCFA-1450 or HCFA-1487) - Full Payment by Automobile Medical, No-Fault, or Liability Insurance.--If the payment from the automobile medical, no-fault, or liability insurer equals or exceeds your charges or the current Medicare interim reimbursement amount or you are obligated to accept the payment as payment in full, do not submit a bill.

E. Home Health Agency Bills (HCFA-1450 or HCFA-1487) - Partial Payment by Automobile Medical, No-Fault, or Liability Insurance.--If the payment from the automobile medical, no-fault, or liability insurer is less than your charges and the current Medicare interim reimbursement amount, and you are not obligated to accept the payment as payment in full, prepare Form HCFA-1450 or HCFA-1487 in accordance with §420 or §475 with the following modifications:

1. Determining charges and visits

Show in the charges and visits columns of the bill Medicare covered charges and visits including those covered by the automobile medical, no-fault, or liability insurer's payment.

2. Determining amount of primary payer payment that applies to Medicare covered services

Where you can determine the primary payer's allocation of its payment between covered and noncovered Medicare services, indicate the amount paid by the primary payer toward Medicare covered services in value codes (items 46-49) on the HCFA-1450 or in the blank space under item 22C on the HCFA-1487. Where you cannot determine the services covered by the primary payment, apply a ratio of Medicare covered charges to total charges for the services to the primary payment amount to determine the portion attributable to Medicare covered services and indicate this amount in value codes (items 46-49) on the HCFA-1450 or in the blank space under item 22C on the HCFA-1487. You must be able to validate your ratio of covered and noncovered charges if so requested.

EXAMPLE:

Total charges were $550. Medicare covered charges were $500. The automobile medical insurer's payment was $330. Since you cannot determine the allocation of the primary payer's payment, determine the allocation as follows:

$$\frac{\$500}{\$550} \times \$330 = \$300$$

Show $300 in value codes (items 46-49) on the HCFA-1450 or in the blank space under item 22C on the HCFA-1487.

3. Determining the amount of Medicare payment

Subtract the payment by the automobile medical, no-fault, or liability insurer for Medicare covered services from the current Medicare interim reimbursement amount.

NOTE: There is no deductible or coinsurance applicable under Part A and B HHA services billed on a HCFA-1450 or HCFA-1487.

EXAMPLE 1: Per Visit Method

A beneficiary received 10 visits for which the current Medicare interim reimbursement amount at $50 per visit interim rate was $500. The automobile medical insurer paid $300 for Medicare covered services as determined in item 2 above. As secondary payer Medicare pays the following:

The Medicare interim reimbursement minus the automobile medical insurer's payment for Medicare covered services: $500 - $300 = $200. Medicare pays $200 as secondary payer.

EXAMPLE 2: Percentage of Billed Charges Method

A beneficiary received 10 visits at $50 per visit. The Medicare interim rate was 90 percent ($500 X 90 percent) which equaled $450. The automobile medical insurer paid $300 for Medicare covered services as determined in item 2 above. As secondary payer Medicare pays the following:

The Medicare interim reimbursement minus the automobile medical insurer's payment for Medicare covered services: $450 - $300 - $150. Medicare pays $150 as secondary payer.

4. Special annotations on the bill

On Form HCFA-1450, show the identifying information in items 57-68 on the first payer line, occurrence code 01, 02, or 03 as appropriate and the associated date in items 28-32, value code 14 with the amount paid in value codes (items 46-49) and the address of the automobile medical, no-fault insurer or the liability insurer in item 34 or remarks (item 94).

On Form HCFA-1487, identify the automobile medical, no-fault insurer, or the liability insurer and enter the amount paid by the automobile medical, no-fault insurer or the liability insurer for Medicare covered services with a statement such as "XYZ Company (amount)" in the blank space under item 22C. In addition, enter the policy number and indicate "automobile accident" or "non-automobile accident" as appropriate.

F. Automobile Medical, No-Fault, or Liability Insurer Does Not Make Payment.--If services are related to an automobile accident and an automobile insurer has been billed but does not make payment, e.g., the services are not covered under automobile medical or no-fault insurance, the individual's insurance coverage expired or an automobile medical or no-fault claim is contested by the insurer or if for any other reason there will be a substantial delay in resolving the claim, bill Medicare as usual. In addition, where you are billing on Form HCFA-1450, show the proper occurrence code and date as indicated below in items 28-32, occurrence codes. Complete occurrence code 24 if applicable to show the date the other payer denied the claim.

01--auto accident
02--auto accident, no-fault insurance
03--accident, court or other legal process pending (non-automobile accident)

Where you are requesting conditional payment because a claim is contested by an automobile medical, no-fault, or liability insurer or for any other reason there will be a substantial delay, complete items 46-49 (value codes) with value code 14 and zero value to indicate the type of other insurer and that conditional payment is requested. Identify the other payer on line A of item 57, and enter on line A of items 65-68 other identifying information about the insured. Enter the address of the automobile medical, no-fault, or liability insurer in item 34 or remarks (item 94). In addition, provide an explanation of why the conditional payment is justified in remarks (item 94).

When billing on Forms HCFA-1483 or HCFA-1487, enter the above information in Remarks.

496. BILL PREPARATION WHERE MEDICARE BENEFITS ARE SECONDARY TO EMPLOYER GROUP HEALTH PLANS WHEN INDIVIDUALS ARE ENTITLED TO BENEFITS SOLELY ON THE BASIS OF ESRD

A. General.—Medicare benefits are secondary to benefits payable under an employer group health plan (EGHP) in the case of individuals who are entitled to benefits solely on the basis of end stage renal disease (ESRD), during a period of up to 12 months. This provision is effective for items and services furnished on or after October 1, 1981, to beneficiaries whose 12-month period began in or after October 1981. For an explanation of these provisions see §252.

Payment made by the ESRD-EGHP will be used to satisfy the unmet deductible and the individual's coinsurance. (See §252.13.)

Annotate all bills with the exception of the HCFA-1450, where Medicare is determined to be primary payer with the statement "Medicare Primary Payer" in the blank space under item 22C when billing on the HCFA-1487 or in "Remarks" when billing on the HCFA-1483. On the HCFA-1450, show Medicare on line A of item 57. Where Medicare is secondary, show Medicare on line B of item 57. In addition, when you are billing Medicare because the ESRD-EGHP denied payment, enter occurrence code 24 (insurance denied) and the date of denial in items 28-32 (occurrence codes) on the HCFA-1450. Enter the reason for the denial in remarks (item 94). On the HCFA-1483 or HCFA-1487, annotate remarks with the statement "ESRD-EGHP: Denied" and provide the reason for denial. Prepare all bills where Medicare is not primary payer because of coverage of an ESRD beneficiary by an EGHP in accordance with the following instructions. In applying the guidelines, it may be necessary to determine the current Medicare interim reimbursement amount (without regard to deductible or coinsurance). See §498 for instructions to determine this amount.

B. Outpatient Bills (HCFA-1450 or HCFA-1483) - Full Payment by Employer Group Health Plan.—Do not submit a bill if an ESRD-EGHP payment equals or exceeds your charges or the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) or you are obligated to accept the ESRD-EGHP payment as payment in full and you know the individual has already met his deductible. However, submit Form HCFA-1450 or HCFA-1483 to inform the intermediary of charges where the deductible may not yet be met. Although no payment can be made by Medicare, the expenses can be applied to the beneficiary's deductible. Complete the bill in the usual manner. In addition:

1. Determine the charges as usual, including those covered by the ESRD-EGHP payment. Your intermediary will treat the charges shown in total charges as noncovered for reimbursement purposes but will credit the deductible based on the bill.

2. Enter the amount paid by the ESRD-EGHP for Medicare covered services in items 46-49 (value codes) on the HCFA-1450 or with the statement "ESRD-EGHP (amount)" in "Remarks" on the HCFA-1483.

3. Enter occurrence code 33 and the first month of the 12-month period in items 28-32, or the first month of the 12 month period in remarks (item 94) on the HCFA-1450. On the HCFA-1483, enter the first month of the 12 month period in remarks.

C. Outpatient Bills (HCFA-1450 or HCFA-1483) - Partial Payment by Employer Group Health Plan.--If an ESRD-EGHP payment is less than your charges and the current Medicare interim reimbursement amount (without regard to deductible or coinsurance), and is not accepted as payment in full, prepare Form HCFA-1450 or HCFA-1483 in accordance with §460 or §475 with the following modifications:

1. Determining covered charges

Show in the covered charges column, Medicare covered charges including those covered by the ESRD-EGHP's payment.

2. Determining amount of primary payment that applies to Medicare covered services

Where you can determine the primary payer's allocation of its payment between covered and noncovered Medicare services, indicate the amount paid by the primary payer toward Medicare covered services in value codes (items 46-49) of the HCFA-1450 or in "Remarks" of the HCFA-1483. Where you cannot determine the services covered by the primary payment, apply a ratio of Medicare covered charges to total charges for the services to the primary payment amount to determine the portion attributable to Medicare covered services and indicate this amount in value codes (items 46-49) of the HCFA-1450 or "Remarks" of the HCFA-1483. You must be able to validate your ratio of covered and noncovered charges, if so requested.

EXAMPLE:

Total charges were $110. Medicare covered charges were $90. The ESRD-EGHP payment was $88. Since you cannot determine the allocation of the primary payer's payment, determine the allocation as follows:

$$\frac{\$90}{\$110} \times \$88 = \$72$$

Show $72 in value codes (items 46-49) of the HCFA-1450 or "Remarks" of the HCFA-1483.

3. Determining the amount of Medicare payment

The amount of Medicare payment is the lower of:

a. The current Medicare interim reimbursement (without regard to deductible or coinsurance) per §498 minus the amount paid by the ESRD-EGHP for Medicare covered services;

b. The current Medicare interim reimbursement (without regard to deductible or coinsurance) per §498 minus any applicable deductible or coinsurance amount.

The amount in total charges which includes the ESRD-EGHP payment is credited toward any unmet deductible regardless of the payment amount.

EXAMPLE 1: ESRD-EGHP payment less than unmet deductible

Outpatient services were furnished to a Medicare beneficiary for which covered charges were $90. No part of the beneficiary's $75 Part B deductible had been met previously. The ESRD-EGHP paid $72 for Medicare covered services as determined in item 2 above. The Medicare interim reimbursement (without regard to deductible and coinsurance amounts) for these services at 90 percent of charges would be $81. As secondary payer, Medicare pays the lower of:

(a) The Medicare interim reimbursement (without regard to deductible and coinsurance amounts) minus the ESRD-EGHP payment: $81 -$72 = $9.

(b) The Medicare interim reimbursement (without regard to deductible and coinsurance amounts) minus the applicable deductible and coinsurance: $81 - $75 - $3* = $3.

*The coinsurance is calculated as follows:

$90 charges - $75 deductible - $15 X 20 percent = $3 coinsurance.

Medicare pays $3. The beneficiary's liability is $6 ($3 of the deductible and the $3 coinsurance). The beneficiary's $75 deductible is satisfied: $72 by the ESRD-EGHP payment and $3 by the beneficiary.

EXAMPLE 2: ESRD-EGHP payment more than unmet deductible

Same facts as in Example (1) above except the ESRD-EGHP's payment for Medicare covered services is $80.

As secondary payer Medicare pays the lower of:

(a) The Medicare interim reimbursment (without regard to deductible or coinsurance amounts) minus the ESRD-EGHP payment: $81 -$80 = $1.

(b) The Medicare interim reimbursement (without regard to deductible or coinsurance amounts) minus the applicable deductible and coinsurance: $81 - $75 - $3* = $3.

*See Example (1) for coinsurance calculation.

Medicare pays $1. You may not charge the beneficiary since the deductible and coinsurance were met by the ESRD-EGHP payment.

EXAMPLE 3: ESRD-EGHP payment equals unmet deductible

Same facts as in Example (1) above except the ESRD-EGHP's payment for Medicare covered services is $75.

As secondary payer Medicare pays the lower of:

(a) The Medicare interim reimbursement (without regard to deductible or coinsurance amounts) minus the ESRD-EGHP payment: $81 - $75 = $6.

(b) The Medicare interim reimbursement (without regard to deductible or coinsurance amounts) minus the applicable deductible or coinsurance: $81 - $75 - $3* = $3.

*See Example (1) for coinsurance calculation.

Medicare pays $3. You may bill the beneficiary $3 for coinsurance. The $75 deductible is satisfied by the ESRD-EGHP payment.

EXAMPLE 4: Deductible met prior to ESRD-EGHP payment.

Same facts as in Example (1) above except the deductible had been met previously.

As secondary payer Medicare pays the lower of:

(a) The Medicare interim reimbursement (without regard to deductible or coinsurance amounts) minus the ESRD-EGHP payment: $81 - $72 = $9.

(b) The Medicare interim reimbursement (without regard to deductible or coinsurance amounts) minus the applicable deductible and coinsurance: $81 - $18* = $63.

*The coinsurance is calculated as follows:

$90 charges X 20 percent = $18 coinsurance.

Medicare pays $9. You may not charge the beneficiary since the coinsurance is paid by ESRD-EGHP payment.

4. Special annotations in "Remarks"

On Form HCFA-1450, show the identifying information in items 57-75 on the first payer line, value code 13 with the amount paid in value codes (items 46-49) and occurrence code 33 and the first month of the 12-month period in items 28-32, or the first month of the 12 month period in remarks (item 94). In addition, enter the address of the ESRD-EGHP in item 34 or remarks (item 94).

On Form HCFA-1450, show the identifying information in items 57-75 on the first payer line, and the amount paid in value codes (items 46-49).

D. Home Health Agency Bills (HCFA-1450 or HCFA-1487) - Full Payment by Employer Group Health Plan.—If the ESRD-EGHP payment equals or exceeds your charges or the current Medicare interim reimbursement amount or is otherwise accepted as payment in full, do not submit a bill.

E. Home Health Agency Bills (HCFA-1450 or HCFA-1487) - Partial Payment by Employer Group Health Plan.—If the ESRD-EGHP payment is less than your charges and the current Medicare interim reimbursement amount, and is not accepted as payment in full, prepare the HCFA-1450 or HCFA-1487 in accordance with §420 or §475 with the following modifications:

1. Determining charges and visits

Show in the charges and visits columns of the bill Medicare covered charges and visits including those covered by the ESRD-EGHP payment.

2. Determining amount of primary payer payment that applies to Medicare covered services

Where you can determine the primary payer's allocation of its payment between covered and noncovered Medicare services, indicate the amount paid by the primary payer toward Medicare covered services in value codes (items 46-49) of the HCFA-1450 or in the blank space under item 22C of the HCFA-1487. Where you cannot determine the services covered by the primary payment, apply a ratio of Medicare covered charges to total charges for the services to the primary payment amount to determine the portion attributable to Medicare covered services and indicate this amount in value codes (items 46-49) of the HCFA-1450 or in the blank space under item 22C of the HCFA-1487. You must be able to validate your ratio of covered and noncovered charges if so requested.

EXAMPLE:

Total charges were $550. Medicare covered charges were $500. The ESRD-EGHP payment was $330. Since you cannot determine the allocation of the primary payer's payment, determine the allocation as follows:

$$\frac{\$500}{\$550} \times \$330 = \$300$$

Show $300 in value codes (items 46-49) of the HCFA-1450 or in the blank space under item 22C of the HCFA-1487.

3. Determining the amount of Medicare payment

Subtract the payment by the ESRD-EGHP for Medicare covered services from the current Medicare interim reimbursement amount.

NOTE: There is no deductible or coinsurance applicable under Part A and B HHA services billed on a HCFA-1450 or HCFA-1487 by an HHA.

EXAMPLE 1: Per Visit Method

A beneficiary received 10 visits for which the current Medicare interim reimbursement amount at \$50 per visit interim rate was \$500. The ESRD-EGHP paid \$300 for Medicare covered services as determined in item 2 above. As secondary payer Medicare pays the following:

The Medicare interim reimbursement minus the ESRD-EGHP payment for Medicare covered services: \$500 - \$300 = \$200. Medicare pays \$200 as a secondary payer.

EXAMPLE 2: Percentage of Billed Charges Method

A beneficiary received 10 visits at \$50 per visit. The Medicare interim rate was 90 percent (\$500 X 90 percent) which equaled \$450. The ESRD-EGHP paid \$300 for Medicare covered services as determined in item 2 above. As secondary payer Medicare pays the following:

The Medicare interim reimbursement minus the ESRD-EGHP's payment for Medicare covered services: \$450 - \$300 - \$150. Medicare pays \$150 as secondary payer.

4. Special annotations on the bill

On Form HCFA-1450, show the identifying information in items 57-75 on the first payer line, value code 13 with the amount in value codes (items 46-49) and occurrence code 33 and the first month of the 12-month period in items 28-32, or the first month of the 12 month period in remarks (item 94). In addition, enter the address of the ESRD-EGHP in item 34 or remarks (item 94).

On Form HCFA-1487, show the amount paid by the ESRD-EGHP for Medicare covered services with the statement, "ESRD-EGHP (amount)" along with the first month of the 12-month period in the blank space under item 22C. In addition, enter the name and address of the ESRD-EGHP through which the insurance is provided to the insured and any identifying information.

F. Conditional Payments.—You are no longer required to bill an ESRD-EGHP first. You may bill either Medicare or the ESRD-EGHP first. If you bill Medicare first, your intermediary will pay conditional primary benefits except where payment has been made by an ESRD-EGHP or the intermediary determines that an ESRD-EGHP will pay "as promptly as Medicare." Since there is no practical way for intermediaries to make uniform determinations as to what constitutes "payment as promptly as Medicare," intermediaries will generally pay conditional payments when billed first.

Where you are billing on Form HCFA-1450, request conditional primary payment by entering value code 13 with zero value in value codes (items 46-49) to indicate the type of other insurer and that conditional payment is requested. Identify the other payer on line A of item 57, enter any identifying information about the insured on line A of items 65-75 and enter the address of the ESRD-EGHP in item 34 or remarks (item 94).

Where billing on Forms HCFA-1483 or HCFA-1487, annotate the "Remarks" portion of the billing form with the statement "ESRD-EGHP: Requesting conditional Medicare benefits." In addition, enter the name of the ESRD-EGHP through which the insurance is provided to the insured and the group number (identification number, control number, or code assigned to identify the group which the individual is covered).

497. BILL PREPARATION WHERE MEDICARE BENEFITS ARE SECONDARY TO EMPLOYER GROUP HEALTH PLANS FOR EMPLOYED BENEFICIARIES AND THEIR SPOUSES AGE 65-69

A. General.—Effective with services provided on or after January 1, 1983, Medicare benefits are secondary to benefits payable under an employer group health plan (EGHP) for employed individuals age 65 through 69 and their spouses age 65 through 69. Effective July 18, 1984, the upper age limit of individuals changes to the month before the month in which the individual attains age 70. Effective for services furnished on or after January 1, 1985, Medicare benefits are secondary to benefits payable under an EGHP for spouses age 65 through 69, of employed individuals of any age through age 69. For an explanation of these provisions see §253.

Payment made by the EGHP can be used to satisfy the unmet deductible and the individual's coinsurance.

Annotate all bills with the exception of the HCFA-1450, where Medicare is determined to be primary payer with the statement "Medicare Primary Payer" in the blank space under item 22C when billing on the HCFA-1487 or in "Remarks" when billing on the HCFA-1483. On the HCFA-1450, show Medicare on line A of item 57. Where Medicare is secondary, show Medicare on line B of item 57. Prepare all bills where Medicare is not primary payer because of EGHP coverage in accordance with the following instructions. In applying the guidelines, it may be necessary to determine the current Medicare interim reimbursement amount (without regard to deductible or coinsurance). See §498 for instructions to determine this amount.

B. Outpatient Bills (HCFA-1450 or HCFA-1483) - Full Payment by Employer Group Health Plan.—Do not submit a bill if an EGHP payment equals or exceeds your charges or the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) or you are obligated to accept the EGHP payment as payment in full and you know the individual has already met his deductible. However, submit Form HCFA-1450 or HCFA-1483 to inform the intermediary of charges where the deductible may not yet be met. Although no payment can be made by Medicare, the expenses can be applied to the beneficiary's deductible. Complete the bill in the usual manner. In addition:

1. Determine the covered charges as usual, including those covered by the EGHP payment. Your intermediary will treat the charges shown in total charges as noncovered for reimbursement purposes but will credit the deductible based on the bill.

2. Enter the amount paid by the EGHP for Medicare covered services in items 46-49 (value codes) on the HCFA-1450 or with the statement "EGHP (amount)" in "Remarks" on the HCFA-1483.

C. Outpatient Bills (HCFA-1450 or HCFA-1483) - Partial Payment by Employer Group Health Plan.—If an EGHP payment is less than your charges and the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) and you are not obligated to accept the EGHP payment as payment in full, prepare Form HCFA-1450 or HCFA-1483 in accordance with §460 or §475 with the following modifications:

1. Determining covered charges

Show in the covered charges column, Medicare covered charges including those covered by the EGHP's payment.

2. Determining amount of primary payment that applies to Medicare covered services

Where you can determine the primary payer's allocation of its payment between covered and noncovered Medicare services, indicate the amount paid by the primary payer toward Medicare covered services in value codes (items 46-49) on the HCFA-1450 or in "Remarks" on the HCFA-1483. Where you cannot determine the services covered by the primary payment, apply a ratio of Medicare covered charges to total charges for the services to the primary payment amount to determine the portion attributable to Medicare covered services and indicate this amount in value codes (items 46-49) on the HCFA-1450 or "Remarks" on the HCFA-1483. You must be able to validate your ratio of covered and noncovered charges, if so requested.

EXAMPLE:

Total charges were $110. Medicare covered charges were $90. The EGHP payment was $88. Since you cannot determine the allocation of the primary payer's payment, determine the allocation as follows:

$$\frac{\$\,90}{\$110} \times \$88 = \$72$$

Show $72 in value codes (items 46-49) on the HCFA-1450 or "Remarks" on the HCFA-1483.

3. Determining the amount of Medicare payment

The amount of Medicare payment is the lower of:

a. The current Medicare interim reimbursement (without regard to deductible or coinsurance) per §498 minus the amount paid by the EGHP for Medicare covered services;

or

b. The current Medicare interim reimbursement (without regard to deductible or coinsurance) per §498 minus any applicable deductible or coinsurance amount.

That portion of the total charges equal to the EGHP payment is credited toward any unmet deductible.

EXAMPLE 1: EGHP payment less than unmet deductible

Outpatient services were furnished to a Medicare beneficiary for which covered charges were $90. No part of the beneficiary's $75 Part B deductible had been met previously. The EGHP paid $72 for Medicare covered services as determined in item 2 above. The Medicare interim reimbursement (without regard to deductible and coinsurance) for these services at 90 percent of charges would be $81. As secondary payer, Medicare pays the lower of:

(a) The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the EGHP payment: $81 - $72 = $9.

(b) The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the applicable deductible and coinsurance: $81 - $75 -$3 = $3.

The coinsurance is calculated as follows:

$90 charges - $75 deductible = $15 x 20 percent = $3 coinsurance.

Medicare pays $3. The beneficiary's liability is $6 ($3 of the deductible and the $3 coinsurance). The beneficiary's $75 deductible is satisfied: $72 by the EGHP payment and $3 by the beneficiary.

EXAMPLE 2: EGHP payment more than unmet deductible

Same facts as in Example (1) above except the EGHP's payment for Medicare covered services is $80.

As secondary payer Medicare pays the lower of:

(a) The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the EGHP payment: $81 - $80 = $1.

(b) The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the applicable deductible and coinsurance: $81 - $75 -$3* = $3.

*See Example (1) for coinsurance calculation.

Medicare pays $1. You may not charge the beneficiary since the deductible and coinsurance were met by the EGHP payment.

EXAMPLE 3: EGHP payment equals unmet deductible

Same facts as in Example (1) above except the EGHP's payment for Medicare covered services is $75.

As secondary payer Medicare pays the lower of:

(a) The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the EGHP payment: $81 - $75 = $6.

(b) The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the applicable deductible or coinsurance: $81 - $75 - $3* = $3.

*See Example (1) for coinsurance calculation.

Medicare pays $3. You may bill the beneficiary $3 for coinsurance. The $75 deductible is satisfied by the EGHP payment.

EXAMPLE 4: Deductible met prior to EGHP payment.

Same facts as in Example (1) above except the deductible had been met previously.

As secondary payer Medicare pays the lower of:

(a) The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the EGHP payment: $81 - $72 = $9.

(b) The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the applicable deductible and coinsurance: $81 - $18* =$63.

*The coinsurance is calculated as follows:

$90 charges X 20 percent = $18 coinsurance.

Medicare pays $9. You may not charge the beneficiary since the coinsurance is satisfied by EGHP payment.

4. Special entries on the bill

On Form HCFA-1450, show the identifying information in items 57-75 on the first payer line, value code 12 with the amount paid in value codes (items 46-49) and the address of the EGHP in item 34 or remarks (item 94).

On Form HCFA-1483, show the amount paid by the EGHP for Medicare covered services with the statement "EGHP (amount)" in "remarks." In addition, enter the name and address of the EGHP through which the insurance is provided to the insured and any identifying information.

D. Home Health Agency Bills (HCFA-1450 or HCFA-1487) - Full Payment by Employer Group Health Plan.--If the EGHP payment equals or exceeds your charges or the current Medicare interim reimbursement amount or you are obligated to accept the EGHP payment as payment in full, do not submit a bill.

E. Home Health Agency Bills (HCFA-1450 or HCFA-1487) - Partial Payment by Employer Group Health Plan.—If the EGHP payment is less than your charges and the current Medicare interim reimbursement amount and you are not obligated to accept the EGHP payment as payment in full, prepare Form HCFA-1450 or HCFA-1487 in accordance with §420 or §475 with the following modifications.

1. Determining charges and visits

Show in the charges and visits columns of the bill Medicare covered charges and visits including those covered by the EGHP payment.

2. Determining amount of primary payer payment that applies to Medicare covered services

Where you can determine the primary payer's allocation of its payment between covered and noncovered Medicare services, indicate the amount paid by the primary payer toward Medicare covered services in value codes (items 46-49) on the HCFA-1450 or in the blank space under item 22C on the HCFA-1487. Where you cannot determine the services covered by the primary payment, apply a ratio of Medicare covered charges to total charges for the services to the primary payment amount to determine the portion attributable to Medicare covered services and indicate this amount in value codes (items 46-49) on the HCFA-1450 or in the blank space under item 22C on the HCFA-1487. You must be able to validate your ratio of covered and noncovered charges if so requested.

EXAMPLE:

Total charges were \$550. Medicare covered charges were \$500. The EGHP payment was \$330. Since you cannot determine the allocation of the primary payer's payment, determine the allocation as follows:

$$\frac{\$500}{\$550} \times \$330 = \$300$$

Show \$300 in value codes (items 46-49) on the HCFA-1450 or in the blank space under item 22C on the HCFA-1487.

3. Determining the amount of Medicare payment

Subtract the payment by the EGHP for Medicare covered services from the current Medicare interim reimbursement amount.

NOTE: There is no deductible or coinsurance applicable under Part A and B HHA services billed on a HCFA-1450 or HCFA-1487 by an HHA.

EXAMPLE 1: Per Visit Method

A beneficiary received 10 visits for which the current Medicare interim reimbursement amount at \$50 per visit interim rate was \$500. The EGHP paid \$300 for Medicare covered services as determined in item 2 above. As secondary payer Medicare pays the following:

The Medicare interim reimbursement minus the EGHP payment for Medicare covered services: \$500 - \$300 = \$200. Medicare pays \$200 as secondary payer.

EXAMPLE 2: Percentage of Billed Charges Method

A beneficiary received 10 visits at \$50 per visit. The Medicare interim rate was 90 percent (\$500 X 90 percent) which equaled \$450. The EGHP paid \$300 for Medicare covered services as determined in item 2 above. As secondary payer Medicare pays the following:

The Medicare interim reimbursement minus the EGHP's payment for Medicare covered services: \$450 - \$300 = \$150. Medicare pays \$150 as secondary payer.

4. Special entries on the bill

On Form HCFA-1450, show the identifying information in items 57-75 on the first payer line, value code 12 with the amount paid in value codes (items 46-49) and the address of the EGHP in item 34 or remarks (item 94).

On Form HCFA-1487, show the amount paid by the EGHP for Medicare covered services with the statement, "EGHP (amount)" in the blank space under item 22C. Include the name and address of the EGHP through which the insurance is provided to the insured and any identifying information.

F. Employer Plan Denies Claim for Primary Benefits.—Where an EGHP denies a claim for primary benefits because the plan offers only secondary coverage of services covered by Medicare, and the plan does not allege the employer has fewer than 20 employees, conditional primary Medicare benefits can be paid. Where billing on Form HCFA-1450, request conditional payment in this case by entering value code 12 with zero value in items 46-49 to indicate the type of other insurer and that a conditional payment is being requested. Enter in items 28-32 (occurrence codes) occurrence code 24 (insurance denied) and the date of denial by the EGHP. Enter the identity of the EGHP on line A of item 57, any identifying information about the insured on line A of items 65-75 and the address of the EGHP in item 34 or remarks (item 94). In addition, enter the annotation "EGHP denied: Plan pays only secondary" in remarks (item 94).

Where billing on Form HCFA-1483 or HCFA-1487, annotate the Remarks portion of the billing form with the statement "EGHP denied: Plan pays only secondary." In addition, enter the name and address of the EGHP through which the insurance is provided to the insured and the group number (identification number, control number or code assigned to identify the group under which the individual is covered).

In all other cases where the EGHP denies payment, enter occurrence code 24 (insurance denied) and the date of denial in items 28-32 (occurrence codes) on the HCFA-1450. In addition, provide a reason for the denial in remarks (item 94). On other billing forms, annotate Remarks with the statement "EGHP: Denied" and provide a reason for the denial.

498. HOW TO DETERMINE CURRENT MEDICARE INTERIM REIMBURSEMENT AMOUNT

Where application of the procedure requires determining the current Medicare interim reimbursement amount, use the following guidelines before adjustment for other insurance payment:

A. Percentage of billed charges - Multiply the current percentage of charges used for the interim rate by the total covered charges. Do not make any reductions for deductible or coinsurance.

B. Per Visit - Multiply the per visit interim rate times the number of covered visits.

C. Periodic Interim Payments (PIP) - Determine a per visit amount based on your current PIP amount (see HCFA-Pub. 15-1 S2407). Multiply this amount by the number of covered Medicare visits.

Your intermediary can advise you of the applicable per diem or percentage rates and of any changes to them.

If you are not on PIP, your interim reimbursement on a bill-by-bill basis will be eliminated or reduced based on instructions in SS494, 495, 496, and 497.

If you are on PIP, a reduction in your interim reimbursement received through PIP is necessary. Where Medicare is determined not to have any liability your PIP amount will be reduced to reflect that no interim reimbursement is due. Where Medicare is determined to be secondarily liable and the primary payer is an insurer addressed in S494 or S495, your PIP amount will be reduced to reflect the primary payment. Where Medicare is determined secondarily liable and the primary payer is an EGHP as addressed in S496 or S497, your PIP amount will be reduced to reflect any excess of the primary payment over the applicable deductible and coinsurance.

Any reduction in your PIP amount may be accomplished by your intermediary offsetting against the next payment, or by taking estimated deductions into account in establishing the PIP amount.

499. PROVIDER SUBMISSION OF ELECTRONIC MEDIA CLAIMS DATA (EMC)

Providers are encouraged to develop the ability to bill Medicare intermediaries electronically where this mode is determined to be cost-effective. You may request from your intermediary the edit specifications in §§ 3871-3874 of the Medicare Intermediary Manual (HCFA Pub. 13) as a reference for use in developing an edit capability. If the data in your electronic media claims conform to these specifications, you should expect the intermediary to process and pay such claims promptly.

499.1 Requirements for Submission of Machine Readable Data.--HCFA's goal is to have all electronic billers submit electronic media claim data to intermediaries using the National Standard Specifications described herein by 1986. In support of this goal, intermediaries are required to receive and process claims reported by billers electronically if the claims adhere to the file and record formats and utilize the data set described in Addendum A (Record Formats), Addendum B (Data Definitions), Addendum C (Coding Structures), and Addendum D (Plan of Treatment Data Definitions and Codes).

We realize that migration from current electronic billing arrangements to the National Standard Specifications will take time. Therefore, we are permitting some short term flexibility. We will temporarily honor approved existing EMC billing arrangements between intermediaries and home health agencies until 1986; and if it promotes movement by home health agencies to electronic media billing, we will permit new providers to use, for EMC, the approved existing specifications currently used by other providers with the same intermediary. Intermediaries may not develop and use file and record formats for EMC that do not conform to the National Standard Specifications. HCFA expects that intermediaries will give payment priority to electronically submitted bills. Intermediaries must continue to comply with existing processing requirements; also, providers must continue to comply with existing data requirements.

A. Provider Representative Certification.--The initial group of claims submitted to an intermediary under these instructions must be accompanied by a covering letter, signed by the provider representative which includes the following statement: "In submitting machine readable claims, I understand that I am certifying that the required patient signatures, or, where applicable, appropriate signatures on behalf of the patient, and required physician certifications and recertifications (PSRO certifications where applicable) are on file and that anyone who misrepresents or falsifies essential Medicare claims information, may, upon conviction be subject to fine and imprisonment under Federal law." The statement should be resubmitted annually, or upon a change in provider representative if that occurs before the year is up.

B. Claims Submission.—

1. Claims data may be submitted to intermediaries in periodic groups/batches at intervals mutually established between intermediary and provider.

2. To the extent possible, multiple beneficiary services received during the same day from a provider must be consolidated and submitted to the intermediary as one claim; e.g., beneficiary receives services from more than one clinic or department of the same provider.

C. Control.—Provider systems must have the capability to resubmit lost or garbled claims data or unreadable tapes, cassettes, floppy disks, or whatever other medium is used, and be able to reassociate data found to be in error with the original claim for correction and resubmission.

D. Retention.—Providers must retain all applicable source data in accordance with existing requirements and make it available for periodic intermediary verification.

499.2 File Specifications, Records Specifications, and Data Element Definitions for Machine Readable Bills.—This material was developed by the Health Care Financing Administration in consultation with the National Association for Home Care, the Blue Cross Association, the Health Insurance Association of America, the Medicaid Systems Technical Advisory Group, and CHAMPUS.

In addition to accommodating the requirements for Medicare claims submitted to Part A intermediaries, and the Medicaid and CHAMPUS counterparts to such billings, it is designed to meet the basic billing needs of private health insurers as represented to HCFA by BCA and HIAA.

Provision has been made for users to expand the file and record format to accommodate needs of a specific locality or type of health insurance coverage. If an entire physical segment is desired within a subset, record types n5 through n9, where n represents 1 through 9, are available for local or specified use. Within the nationally defined physical segments where space permits a portion is set aside for local use. The File and Record Formats are described in Addendum A. The data elements are listed alphabetically and defined in Addendum B. Coding structures for data represented by codes are defined in Addendum C. Addendum D defines the data elements and coding structures used in the Plan of Treatment record - Record Type 71.

499.3 Maintenance of National Formats.—The maintenance of the file and record formats described below is the responsibility of a committee chaired by HCFA's Director of the Division of Methods and Systems Requirements, known as the Provider Electronic Billing Technical Advisory Group—PEBTAG. Other groups currently represented on the PEBTAG are the National Association for Home Care, the Health Insurance Association of America, the Blue Cross Association, the Medicaid Systems Technical Advisory Group, and CHAMPUS. The PEBTAG meets ad hoc at a time and place designated by the chairman.

ADDENDUM A - PROVIDER ELECTRONIC BILLING FILE AND RECORD FORMATS

	Section	Page
Recommended Physical File Specifications - Magnetic Tape	1	A-2
File Specifications - Media Other Than Magnetic Tape	2	A-3
File Logic Flowchart	3	A-4
File Logic Specifications	4	A-5
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1. Recommended Physical File Specifications - Magnetic Tape.—Tape Characteristics -9 Track, 8 1/2" to 10 1/2" reels with silver mylar reflector (standard reels) with write ring removed.

Parity - Odd

Recording Density - 1600 bytes per inch.

Recording Code - Extended Binary Coded Decimal.

File Label - None. The tape must have an end of file mark. The first data record on the file will identify the submitter and the receiver, and will serve the function of a file label.

Physical Record Length - 192 characters.

Block Size: 1920 characters; i.e., a blocking factor of 10.

Unfilled Final Block - Fill with spaces.

The external label on the reel must appear as follows:

From ____a____ To ____b____
Reel Number ___c___ Claim Types ___d___
Billing Date ___e___
f. ☐ Medicare ☐ Medicaid ☐ Other
Recording Density 1600 BPI

(a) Identification of submitter
(b) Identification of intended recipient
(c) Unique number by which tape is identified in submitter's tape library
(d) Types of claims on the tape; e.g., inpatient hospital, inpatient SNF, outpatient hospital, etc.
(e) Date tape created (MMDDYY)
(f) Check one: Medicare, Medicaid, or Other

2. **File Specifications - Media Other Than Magnetic Tape.**—

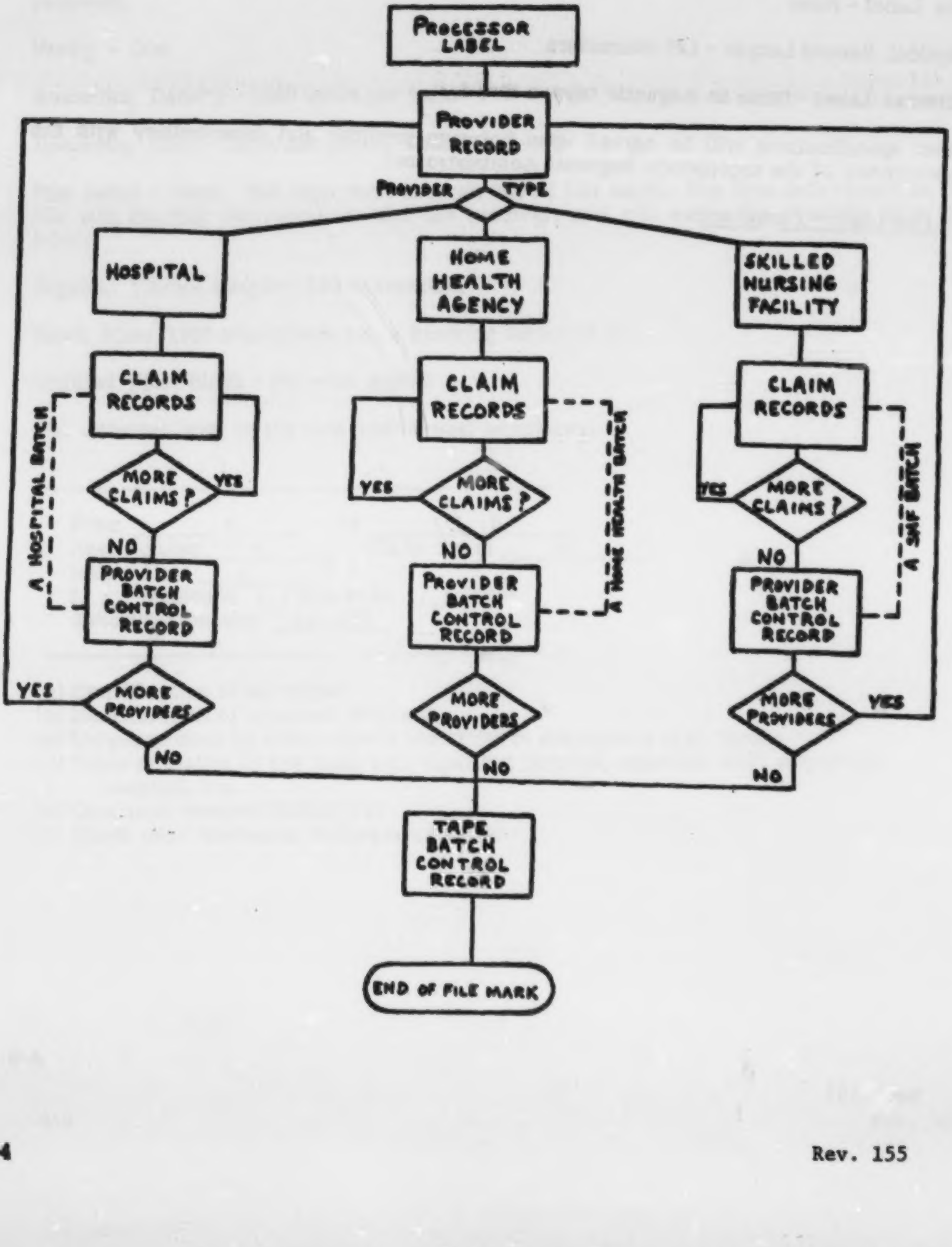
File Label - None

Physical Record Length - 192 characters

External Label - Same as magnetic tape, a thru f

Other specifications will be agreed upon between provider and intermediary with the concurrence of the appropriate Regional Administrator.

3. **File Logic - Flowchart.**—


PROCESSOR LABEL
PROVIDER RECORD
PROVIDER TYPE
HOSPITAL
HOME HEALTH AGENCY
SKILLED NURSING FACILITY
CLAIM RECORDS
MORE CLAIMS?
YES
NO
PROVIDER BATCH CONTROL RECORD
A HOSPITAL BATCH
A HOME HEALTH BATCH
A SNF BATCH
MORE PROVIDERS
YES
NO
TAPE BATCH CONTROL RECORD
END OF FILE MARK

4. Record Specifications.—The logical claim record is made up of a series of 192 character physical records. The physical records for each claim are divided into logical subsets as follows:

Subset 1 - Patient Data - Record Codes 20-29
Subset 2 - Third Party Data - Record Codes 30-39
Subset 3 - Claim Data - Record Codes 40-49
Subset 4 - Inpatient Accommodations Data - Record Codes 50-59
Subset 5 - Ancillary Services Data - Record Codes 60-69
Subset 6 - Medical Data - Record Codes 70-79
Subset 7 - Physician Data - Record Codes 80-89

A. The record layouts that follow will provide the following data:

1. Record Name: The name of this data record.
2. Record Type: Code indicating the type of record.
3. Record Size: Physical length of record. Constant 192.
4. Field Number
5. Field Name
6. Picture: this will be the COBOL picture. Pic X will be initialized to blanks, and Pic 9 will be initialized to zeroes. All money fields and date fields will be Pic 9. All code fields that have a legitimate value of zero will be Pic X. This will make it possible to detect whether the field has been omitted.
7. Field Specification: This simply indicates how the data field is justified. L = Left justification, and R = Right justification.
8. Position
   From = Leftmost position in the record (high order).
   Thru = Rightmost position in the record (low order).

5. Key to Records

Record Name	Record Type Code
Processor Data	01
Reserved for National Assignment	02-04
Local Use	05-09
Provider Data	10
Reserved for National Assignment	11-14
Local Use	15-19
Patient Data	20
Non-insured Employment	21
Reserved for National Assignment	22-24
Local Use	25-29
Third Party Insurer Data	30-31
Reserved for National Assignment	32-34
Local Use	35-39
Claim Data	40
Reserved for National Assignment	41-44
Local Use	45-49
Accommodations Data	50
Reserved for National Assignment	51-54
Local Use	55-59
Ancillary Data	60
Reserved for National Assignment	61-64
Local Use	65-69
Medical Data	70
Reserved for National Assignment	71-74
Local Use	75-79
Physician Data	80
Reserved for National Assignment	81-84
Local Use	85-89
Screen	90
Reserved for National Assignment	91-94
Batch Control	95
Local Use	96-98
Tape Control	99

6. Record Layouts

RECORD TYPE 01 - PROCESSOR DATA

- Must be first record on tape
- Must be followed by RT 10.

NOTE: 1) Tapes will be formatted so that this is a data record, not a conventional label. From a system standpoint this will be a 'labelless' tape.

2) The processor data record will be the first record on each reel.

3) This record indicates, in fields 5 thru 7, the class of and identification of the organization designated to receive this tape or transmission. If the code in field 5 is a "Z," the file contains records for multiple primary payers. In this case, the employer identification number (EIN), also known as the tax identification number (TIN), identifies the organization designated to receive this tape or transmission. Otherwise, the code in field five designates the types of primary payer, field 6 contains the receiver/primary payer identification (NAIC number for commercials, Blue Cross number for PLANS, as indicated by each State agency for Medicaid, as assigned by CHAMPUS where applicable, etc.). For commercial insurers, Field 7 contains the specific office within the insurance carrier designated to receive this tape or transmission. For Blue Cross plans this field will be used as designated by the Plan receiving the file.

4) It is recommended that billers and intermediaries establish a protocol limiting a file to a single reel of tape, single disk, cassette, etc. In the event a file exceeds that limit, the reel, disk, etc. must end in a batch control (record type 95).

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Processor Data	01	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION FROM	POSITION THRU
1	Record type '01'	XX	L	1	2
2	Submitter EIN	9(9)	L	3	11
3	Multiple Provider Billing Tape Indicator	9		12	12
4	Filler	X(18)	L	13	30
5	Receiver Type Code	X		31	31
6	Receiver Identification	9(5)	L	32	36
7	Receiver Sub-Identification	X(4)	L	37	40
8	Processing Date ("Date Bill Submitted" on HCFA-1450)	9(6)	L	41	46
9	Submitter Name	X(21)	L	47	67
	Submitter Address (Fields 10-13)				
10	Address	X(18)	L	68	85
11	City	X(15)	L	86	100
12	State	XX	L	101	102
13	Zip	X(9)	L	103	111
14	Submitter Telephone Number	X(10)	L	112	121
15	Reel Sequence Number	9		122	122
16	Reel Serial Number	X(6)	L	123	128
17	Filler (Reserved for National use)	X(32)		129	160
18	Filler (reserved for local use)	X(29)		161	189
* 19	Version Code	XXX	L	190	192

VERSION 001

RECORD TYPE 10 - PROVIDER

- Must follow either RT 01 or 95.
- Must be followed by RT 20.

NOTE: THIS RECORD MUST BE PRESENT FOR EACH PROVIDER, BATCH COMBINATION.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Provider	10	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record type '10'	XX	L	1	2
2	Type of Batch	XXX	L	3	5
3	Batch Number	99	R	6	7
4	Federal Tax Number	9(9)	L	8	16
5	Filler	X(6)	L	17	22
6	Medicare Provider Number	X(8)	L	23	30
7	Reserved for Medicare	X(2)	L	31	32
8	Medicaid provider number	X(12)	L	33	44
9	Reserved for Medicaid	X(4)	L	45	48
10	Blue Cross/Blue Shield Provider Number	X(13)	L	49	61
11	Filler	X(9)	L	62	70
12	Provider Telephone Number	X(10)	L	71	80
13	Provider Name	X(18)	L	81	98
	Provider Address (Fields 14-17)				
14	Address	X(18)	L	99	116
15	City	X(15)	L	117	131
16	State	XX	L	132	133
17	Zip	X(9)	L	134	142
18	Procedure Coding Method Used	9		143	143
19	Filler (reserved for national use)	X(25)		144	168
20	Filler (reserved for local use)	X(24)		169	192

RECORD TYPES 20-2N - Patient

- Must follow either RT 10 or RT 90.
- May be followed by RT 21-2N or 30.
- All records following to RT 90 must have the same patient control number.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	**Record Type**	**Record Size**
Patient	**20**	**192**

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record type '20'	XX	L	1	2
2	Filler	XX		3	4
3	Patient Control Number	X(17)	L	5	21
	Patient Name (Fields 4-6)				
4	Last Name	X(20)	L	22	41
5	First Name	X(10)	L	42	51
6	Middle Initial	X		52	52
7	Patient Sex	X		53	53
8	Patient Birthdate (MMDDYYYY)	9(8)	L	54	61
9	Patient Marital Status	X		62	62
10	Type of Admission	X		63	63
11	Source of Admission	X		64	64
12	Accident Hour	XX	R	65	66
	Patient Address (Fields 13-17)				
13	Address - Line 1	X(18)	L	67	84
14	Address - Line 2	X(18)	L	85	102
15	City	X(15)	L	103	117
16	State	XX	L	118	119
17	Zip	X(9)	L	120	128
18	Admission Date	9(6)	L	129	134
19	Admission Hour	XX	R	135	136
	Statement Covers Period				
20	From (MMDDYY)	9(6)	L	137	142
21	Thru (MMDDYY)	9(6)	L	143	148
22	Patient Status	99	R	149	150
23	Discharge Hour	XX	R	151	152
24	Patient Has Paid	9(5)V99	R	153	159
25	Medical Record Number	X(18)	L	160	177
26	Filler (Local Use)	X(15)		178	192

RECORD TYPE 21 - Non-insured Employment Information

- Must follow RT 20.
- May be followed by RT 21-2N or 30.
- This record contains employment information pertaining to individuals not claiming insurance but who may have some insurance coverage through their employer from which the patient may be eligible for benefits.
- There are four different individuals to whom this may apply: the patient, the patient's spouse, the patient's father, and the patient's mother. If more than two of these individuals are involved in this claim, a second record type 21 is to be used to submit the relevant employment data for the third, and if applicable, the fourth party involved. The sequence number (field 2) of the second Type 21 record would be shown as "2".

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Non-insured employment	21	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record type '21'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(17)	L	5	21
	EMPLOYMENT INFORMATION PACKET ONE				
4	Employer Name	X(18)	L	22	39
	Employer Location (Fields 5 - 8)				
5	Employer Address	X(18)	L	40	57
6	Employer City	X(15)	L	58	72
7	Employer State	XX	L	73	74
8	Employer Zip	X(9)	L	75	83
9	Employee ID Number	X(12)	R	84	95
10	Employment Information Data (P,S,M, or F only)	X		96	96
11	Employment Status Code	9		97	97
	EMPLOYMENT INFORMATION PACKET TWO				
12	Employer Name	X(18)	L	98	115
	Employer Location (Fields 5 - 8)				
13	Employer Address	X(18)	L	116	133
14	Employer City	X(15)	L	134	148
15	Employer State	XX	L	149	150
16	Employer Zip	X(9)	L	151	159
17	Employee ID Number	X(12)	R	160	171
18	Employment Information Data (P,S,M, or F only)	X		172	172
19	Employment Status Code	9		173	173
20	Filler	X(19)		174	192

RECORD TYPES 30-3N - Third Party Payer

One third party payer record packet (record types 30-3N) will appear in the bill record for each payer involved in the bill. Each third party payer packet must contain a record type 30. However, each record type 30 may or may not have an associated record type 31, etc. depending on the specific third party payer data required by the particular payer.

Example: Medicare is primary, and the secondary payer requires the insured's address:

	Record Type Code	**Sequence Number**
Medicare	**30**	**01**
Secondary Payer	**30**	**02**
	31	**02**

Note that the sequence number of the type 31 record for the secondary payer matches the sequence number of the secondary payer's type 30 record, serving as a matching criterion for the specific third party payer record packet.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Third Party Payer	30	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION FROM	POSITION THRU
1	Record type '30'	XX	L	1	2
2	Sequence Number	99	L	3	4
3	Patient Control Number	X(17)	L	5	21
4	Source of Payment Code	X		22	22
5	Payer Identification	9(5)	L	23	27
6	Payer Sub-Identification	X(4)	L	28	31
7	Certificate/Social Security Number/ Health Insurance Claim/ Identification Number	X(17)	L	32	48
8	Payer Name	X(16)	L	49	64
9	Primary Payer Code	X		65	65
10	Insurance Group Number	X(20)	L	66	85
11	Insured Group Name	X(17)	L	86	102
	Insured's Name (Fields 11-13)				
12	Last Name	X(20)	L	103	122
13	First Name	X(10)	L	123	132
14	Middle Initial	X		133	133
15	Insured's Sex	X		134	134
16	Release of Information Certification Indicator	X		135	135
17	Assignment of Benefits Certification Indicator	X		136	136
18	Patient's Relationship to Insured	99	L	137	138
19	Employment Status Code	9		139	139
20	Covered Days	999	R	140	142
21	Non-Covered Days	9999	R	143	146
22	Coinsurance Days	999	R	147	149
23	Lifetime Reserve Days	99	R	150	151
24	Deductible	9(6)V99	R	152	159
25	Co-Insurance	9(6)V99	R	160	167
26	Estimated Amount Due	9(6)V99	R	168	175
27	Estimated Responsibility	9(6)V99	R	176	183
28	Prior Payments	9(6)V99	R	184	191
29	Filler	X		192	192

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Third Party Payer	31	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record type '31'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(17)	L	5	21
	Insured's Address (Fields 4-8)				
4	Address - Line 1	X(18)	L	22	39
5	Address - Line 2	X(18)	L	40	57
6	City	X(15)	L	58	72
7	State	XX	L	73	74
8	Zip	X(9)	L	75	83
9	Employer Name	X(18)	L	84	101
	Employer Location (Fields 10 - 13)				
10	Employer Address	X(18)	L	102	119
11	Employer City	X(15)	L	120	134
12	Employer State	XX	L	135	136
13	Employer Zip	X(9)	L	137	145
14	Employee ID Number	X(12)	R	146	157
15	Special Program Indicator	99	R	158	159
16	Filler (reserved for national use)	X(10)		160	169
17	Filler (reserved for local use)	X(23)		170	192

RECORD TYPE 40 - 4N - CLAIM

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Claim = '40'	40	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION FROM	POSITION THRU
1	Record Type '40'	XX	L	1	2
2	Filler	XX		3	4
3	Patient Control Number	X(17)	L	5	21
4	Type of Bill	999	R	22	24
5	PSRO/PRO Approval Indicator	9		25	25
	PSRO/PRO Approved Stay Dates				
6	FROM (MMDDYY)	9(6)	L	26	31
7	THRU (MMDDYY)	9(6)	L	32	37
8	Number of Grace Days	X		38	38
9	Treatment Authorization Code	X(10)	L	39	48
10	Blood - Furnished Pints	999	R	49	51
11	Blood - Replaced Pints	999	R	52	54
12	Blood - Unreplaced Pints	999	R	55	57
13	Blood - Deductible Pints	99	R	58	59
14	Occurrence Code - 1	99	R	60	61
15	Occurrence Date - 1 (MMDDYY)	9(6)	L	62	67
16	Occurrence Code - 2	99	R	68	69
17	Occurrence Date - 2 (MMDDYY)	9(6)	L	70	75
18	Occurrence Code - 3	99	R	76	77
19	Occurrence Date - 3 (MMDDYY)	9(6)	L	78	83
20	Occurrence Code - 4	99	R	84	85
21	Occurrence Date - 4 (MMDDYY)	9(6)	L	86	91
22	Occurrence Code - 5	99	R	92	93
23	Occurrence Date - 5 (MMDDYY)	9(6)	L	94	99
24	Occurrence Span Code - 1	99	L	100	101
	Occurrence Span Date - 1 (Fields 25-26)				
25	Occurrence Span FROM DATE - 1 (MMDYY)	9(6)	L	102	107
26	Occurrence Span THRU DATE - 1 (MMDDYY)	9(6)	L	108	113

NOTE: IF THE CODE IN THE OCCURRENCE CODE FIELD IS OVER 69 THE TWO DATE FIELDS FOLLOWING THAT CODE ARE ASSOCIATED WITH IT, AND THE FIELD FOLLOWING THE FIRST DATE IS ZERO. IF THE CODE ENCOUNTERED IN THE OCCURRENCE SPAN CODE FIELD IS LESS THAN 70, ONLY THE OCCURRENCE SPAN FROM DATE WILL BE COMPLETED. THE CODE AND DATE WILL BE INTERPRETED AS AN OCCURRENCE CODE.

Claim = 40

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
27	Condition Code - 1	99	R	114	115
28	Condition Code - 2	99	R	116	117
29	Condition Code - 3	99	R	118	119
30	Condition Code - 4	99	R	120	121
31	Condition Code - 5	99	R	122	123
32	Value Code - 1	99	R	124	125
33	Value Amount - 1	9(4)V99	R	126	131
34	Value Code - 2	99	R	132	133
35	Value Amount - 2	9(4)V99	R	134	139
36	Value Code - 3	99	R	140	141
37	Value Amount - 3	9(4)V99	R	142	147
38	Value Code - 4	99	R	148	149
39	Value Amount - 4	9(4)V99	R	150	155
40	Value Code - 5	99	R	156	157
41	Value Amount - 5	9(4)V99	R	158	163
42	Value Code - 6	99	R	164	165
43	Value Amount - 6	9(4)V99	R	166	171
44	Value Code - 7	99	R	172	173
45	Value Amount - 7	9(4)V99	R	174	179
46	Value Code - 8	99	R	180	181
47	Value Amount - 8	9(6)V99	R	182	189
48	Filler	X(3)		190	192

If there is a payer primary to Medicare, Value Code 8 is used to identify the reason, and the amount paid by such a payer which would otherwise have been covered by Medicare is to be shown in Value Amount 8.

RECORD TYPE 50 - ACCOMMODATION

May be preceded by RT 40 - 4n or 50 - 5n.

May be followed by RT 50 - 5n, 60 or 70.

Accommodations should be entered in the sequence in which they occur (date sequence).

The sequence number for record type 50 can go from 01 to 99, each such physical record containing five accommodations, thus making provision for reporting up to 495 accommodations on a single claim.

ACCOMMODATION REVENUE CODES: 100 THRU 22X

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
IP Accommodations	50	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION FROM	POSITION THRU
1	Record type '50'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(17)	L	5	21
	Accommodations (occurs 5 times)				
	Accommodations - 1	9(33)	L	22	54
4	Accommodations Revenue Code	999	L	22	24
5	Filler	9		25	25
6	Accommodations Rate	9(4)V99	R	26	31
7	Accommodations Days	9(4)	R	32	35
8	Accommodations Total Charges	S9(5)V99	R	36	42
9	Accommodations Non-Covered Charges	S9(5)V99	R	43	49
10	Filler	9(5)	L	50	54
11	Accommodations - 2	9(33)	L	55	87
12	Accommodations - 3	9(33)	L	88	120
13	Accommodations - 4	9(33)	L	121	153
14	Accommodations - 5	9(33)	L	154	186
15	Filler	X(6)	L	187	192

RECORD TYPE 60 - ANCILLARY SERVICES

May be preceded by RT 40, 50 - 5n or 60 - 6n.

May be followed by RT 60 - 6n, 70 or 80.

The sequence number for record type 60 can go from 01 to 99, each such physical record containing five ancillary service codes, thus making provision for reporting up to 495 ancillary services on a single claim.

PAYER AND RELATED INFORMATION (codes 001 - 099).

THESE CODES SHOULD BE REPORTED IN RECORD TYPE 60, BUT THE AMOUNTS ASSOCIATED WITH THEM ARE NOT TO BE INCLUDED IN CONTROL TOTALS FOR ANCILLARIES IN RECORD TYPES 90 THRU 9N.

ANCILLARY SERVICES REVENUE CODES: **CODES 220 - 99X.**

ANCILLARY CODES SHOULD BE IN REVENUE CODE NUMBER SEQUENCE

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Ancillary Services	60	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION FROM	POSITION THRU
1	Record type '60'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(17)	L	5	21
	Ancillaries (occurs 5 times)				
	Ancillaries - 1	9(32)	L	22	53
4	Ancillary Revenue Code	9(3)	L	22	24
5	Filler	9(6)	L	25	30
6	Ancillary Date of Service	9(6)	L	31	36
7	Ancillary Units of Service	999	R	37	39
8	Ancillary Total Charges	S9(5)V99	R	40	46
9	Ancillary Non-Covered Charges	S9(5)V99	R	47	53
10	Ancillaries - 2	9(32)		54	85
11	Ancillaries - 3	9(32)		86	117
12	Ancillaries - 4	9(32)		118	149
13	Ancillaries - 5	9(32)		150	181
14	Filler	X(11)		182	192

RECORD TYPE 61 - PROCEDURES

May be preceded by RT 40, 50 - 5n, 60, or 61.

May be followed by RT 61 - 6n, 70 or 80.

The sequence number for record type 61 can go from 01 to 99, each such physical record containing five procedure codes, thus making provision for reporting up to 495 procedures on a single claim.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Procedures	61	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION FROM	POSITION THRU
1	Record type '61'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(17)	L	5	21
	Procedures (occurs 5 times)				
	Procedures - 1	9(32)	L	22	53
4	Procedure Code	9(5)	L	22	26
5	Modifier 1 (CPT4 & HCPCS)	99	L	27	28
6	Modifier 2 (CPT4 & HCPCS)	99	L	29	30
6	Procedure Date of Service	9(6)	L	31	36
7	Procedure Units of Service	999	R	37	39
8	Procedure Total Charges	S9(5)V99	R	40	46
9	Procedure Non-Covered Charges	S9(5)V99	R	47	53
10	Procedures - 2	9(32)		54	85
11	Procedures - 3	9(32)		86	117
12	Procedures - 4	9(32)		118	149
13	Procedures - 5	9(32)		150	181
14	Filler	X(11)		182	192

* The individual data elements are not included in the alphabetic glossary. Each relates directly to the parallel field in the type 60 record. The only fields without parallel in the type 60 record are the two modifiers which are defined in the HCPCS and the CPT-4 Manuals.

RECORD TYPE 70 - 7N - MEDICAL

May be preceded by RT 50, 60, or 61.

May be followed by RT 7N, 80 or 90.

NOTE: THE ICD-9-CM DIAGNOSIS CODES HAVE BEEN ASSIGNED A COBOL PICTURE OF X. THE ACTUAL CODE WILL BE FORMATTED IN ONE OF FOUR GENERAL WAYS:

1	**999.99**	**MAY INCLUDE ZERO TO TWO DECIMAL PLACES.**
2	**V99.99**	**MAY INCLUDE ZERO TO TWO DECIMAL PLACES.**
3	**E999.9**	**MAY INCLUDE ZERO TO ONE DECIMAL PLACE.**
4	**M9999**	**INCLUDES NO DECIMAL PLACES.**

TO DETERMINE THE LOCATION OF THE DECIMAL POSITION AND THE POTENTIAL NUMBER OF DECIMAL POSITIONS IT IS NECESSARY ONLY TO EXAMINE THE HIGH ORDER (LEFTMOST) POSITION IN THE FIELD.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Medical	70	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record Type '70'	XX	L	1	2
2	Filler	XX		3	4
3	Patient Control Number	X(17)	L	5	21
4	Principal Diagnosis Code	X(5)	L	22	26
	Other Diagnosis Codes (fld. 5-8)				
5	Other Diagnosis Code	X(5)	L	27	31
6	Other Diagnosis Code	X(5)	L	32	36
7	Other Diagnosis Code	X(5)	L	37	41
8	Other Diagnosis Code	X(5)	L	42	46
9	Principal Procedure Code	X(5)	L	47	51
10	Filler	X(4)	L	52	55
11	Principal Procedure Date	9(6)	L	56	61
	Other Procedure Codes and Dates (fld. 12 through 17).				
12	Other Procedure Code	X(5)	L	62	66
13	Filler	X(4)	L	67	70
14	Other Procedure Date	9(6)	L	71	76
15	Other Procedure Code	X(5)	L	77	81
16	Filler	X(4)	L	82	85
17	Other Procedure Date	9(6)	L	86	91
18	Filler	X(15)		92	106
19	Principal and Other Diagnoses Descriptions	X(45)	L	107	151
20	Principal and Other Procedures Descriptions	X(41)	L	152	192

RECORD TYPES 71-74 - HOME HEALTH DATA ELEMENTS FOR MEDICAL REVIEW OF HOME HEALTH CLAIMS

Must be preceded by RT 70

May be followed by RT 7N, 80 or 90

RECORD TYPE 71 -HOME HEALTH CERTIFICATION AND PLAN OF TREATMENT (FORM HCFA-485)
RECORD TYPE 72 -MEDICAL UPDATE AND PATIENT INFORMATION (FORM HCFA-486)
RECORD TYPE 73 -PLAN OF TREATMENT/MEDICAL UPDATE NARRATIVE
RECORD TYPE 74 -MEDICAL UPDATE/PATIENT INFORMATION NARRATIVE

Use to submit data from the forms HCFA-485 and 486. Data is required with the initial Home Health bill and with subsequent bills closest to the recertification dates. Record types 71, 72 and 73 must always be present. Record Type 74 must be present if Record Type 72, Fields 4, 5, 42 or 43 contain a positive response, i.e., code=1.

Retain signed copies of the forms HCFA-485 and 486 in your files. Submit the Provider Representative Certification with the initial batch of claims containing the HCFA 485 and HCFA 486 data elements. Submit subsequent certifications in accordance with §499.1.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
HOME HEALTH CERTIFICATION AND PLAN OF TREATMENT (P.1)	71	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION	
				FROM	THRU
1	Record Type'71'	XX	L	1	2
2	Filler	XX	L	3	4
3	Patient Control Number	X(17)	L	5	21
	Certification Period				
4	From (MMDDYY)	9(6)	L	22	27
5	To (MMDDYY)	9(6)	L	28	33
6	Start of Care Date (MMDDYY)	9(6)	L	34	39
7	Date of Onset/ Exacerbation of Principal Diagnosis (MMDDYY)	9(6)	L	40	45
8	Surgical Procedure Code	X(4)	L	46	49
9	Date Surgical Procedure Performed (MMDDYY)	9(6)	L	50	55
	Dates of Onset/Exacerbation of Secondary Diagnoses (occurs 4 times)				
10	Date Secondary Diagnosis-1	9(6)	L	56	61
11	Date Secondary Diagnosis-2	9(6)	L	62	67
12	Date Secondary Diagnosis-3	9(6)	L	68	73
13	Date Secondary Diagnosis-4	9(6)	L	74	79
	Functional Limitations (occurs 3 times)				
14	Code-1	X		80	80
15	Code-2	X		81	81
16	Code-3	X		82	82
	Activities Permitted (occurs 3 times)				
17	Code-1	X		83	83
18	Code-2	X		84	84
19	Code-3	X		85	85
	Medications (occurs 6 times)				
	Medication-1	X(15)	L	86	100

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
HOME HEALTH CERTIFICATION AND PLAN OF TREATMENT (P.2)	71	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
20	Drug/Mode	X(5)	L	86	90
21	Dosage	X(4)X(2)	L	91	96
22	Frequency	X(3)	L	97	99
23	Indicator	X		100	100
24	Medication-2	X(15)	L	101	115
25	Medication-3	X(15)	L	116	130
26	Medication-4	X(15)	L	131	145
27	Medication-5	X(15)	L	146	160
28	Medication-6	X(15)	L	161	175
	Mental Status (occurs 2 times)				
29	Code-1	X		176	176
30	Code-2	X		177	177
31	Prognosis	X		178	178
32	Filler (National Assignment)	X(3)		179	181
33	Filler (State Assignment)	X(11)		182	192

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
MEDICAL UPDATE AND PATIENT INFORMATION	72	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION FROM	POSITION THRU
1	Record Type '72'	XX	L	1	2
2	Filler	XX	L	3	4
3	Patient Control Number	X(17)	L	5	21
4	Place of Service Indicator	X		22	22
5	Additional Care Indicator	X		23	23
	Dates of Last Inpatient Stay				
6	From MMDDYY	9(6)	L	24	29
7	To MMDDYY	9(6)	L	30	35
8	Type of Facility	X		36	36
9	Date Physician Last Saw Patient MMDDYY	9(6)	L	37	42
	Specific Services and Treatment (occurs 6 times)				
	Occurrence-1	X(23)	L	43	65
10	Type of Visits	9		43	43
11	Number of Visits	99	R	44	45
12	Frequency of Visits	X		46	46
13	Duration of Visits	XX	L	47	48
14	Frequency of Visits	X		49	49
15	Duration of Visits	XX	L	50	51
16	Frequency of Visits	X		52	52
17	Duration of Visits	XX	L	53	54
18	Treatment Code	X(3)	L	55	57
19	Treatment Code	X(3)	L	58	60
20	Treatment Code	X(3)	L	61	63
21	Number of Visits on Bill Ordered in Prior Period	99	R	64	65
22	Occurrence-2	X(23)	L	66	88
23	Occurrence-3	X(23)	L	89	111
24	Occurrence-4	X(23)	L	112	134
25	Occurrence-5	X(23)	L	135	157
26	Occurrence-6	X(23)	L	158	180

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
MEDICAL UPDATE AND PATIENT INFORMATION	72	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION FROM	POSITION THRU
27	Number of Times Patient Not at Home When Agency Visited	X		181	181
28	Frequency Patient Leaves Home for Medical Reasons	X		182	182
29	Frequency Patient Leaves Home for Nonmedical Reasons	X		183	183
30	Able and Willing Care Giver Available	X		184	184
31	Supplemental Plans of Treatment on File	X		185	185
32	Filler	X(7)		186	192

RECORD TYPE 73 - PLAN OF TREATMENT/MEDICAL UPDATE NARRATIVE

This record(s) contains narrative information from the forms "Home Health Certification and Plan of Treatment" and "Medical Update and Patient Information." There will be a separate 73 record generated for each of the following narratives:

Narrative	Data ID Number
Significant Clinical Findings	01
Physicians' Orders	02
Updated Information	03
Reason Homebound/ Functional Limitations Rehabilitation Potential/ Goals	04

The sequence number will be incremented by one for each 73 record present (i.e., 01-99). Additional 73 records can be used if necessary. A narrative must always be present to document significant clinical findings and reason homebound/functional limitations/rehabilitation potential/goals. Physicians' orders are required to give information not covered by treatment codes contained in RT 72. Updated information is required when significant events have occurred which are not documented in clinical findings or elsewhere in the records.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
PLAN OF TREATMENT/ MEDICAL UPDATE NARRATIVE	73	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION FROM	POSITION THRU
1	Record Type '73'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(17)	L	5	21
4	Filler	XX		22	23
5	Data ID Number 01-04	XX		24	25
6	Corresponding Data	X(167)		26	192

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
MEDICAL UPDATE AND PATIENT INFORMATION NARRATIVE	74	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record Type '74'	XX	L	1	2
2	Filler	XX		3	4
3	Patient Control Number	X(17)	L	5	21
4	Filler	XX		22	23
5	Name of Nursing Home	X(18)	L	24	41
6	Nursing Home Address	X(18)	L	42	59
7	NH City	X(15)	L	60	74
8	NH State	XX	L	75	76
9	NH Zip	X(9)	L	77	85
	Additional Care Not Paid for by Medicare				
	Service (occurs 4 times)				
10	Service - 1	XX	L	86	87
11	Service - 2	XX	L	88	89
12	Service - 3	XX	L	90	91
13	Service - 4	XX	L	92	93
	Payor Source for Service (occurs 2 times)				
14	Payor - 1	X(15)	L	94	108
15	Payor - 2	X(15)	L	109	123
16	Available Care Giver	X(30)	L	124	153
17	Supplemental Plans of Treatment	X(39)	L	154	192

RECORD TYPE 80 - 8N - PHYSICIAN DATA

- May follow RT 50, 60, or 70 - 7N.
- May be followed by RT 8N, or 90.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Physician Data	80	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record Type '80'	XX	L	1	2
2	Filler	XX	L	3	4
3	Patient Control Number	X(17)	L	5	21
4	Attending Physician Number	X(16)	L	22	37
5	Operating Physician Number	X(16)	L	38	53
6	Other Physician Number	X(16)	L	54	69
7	Other Physician Number	X(16)	L	70	85
8	Attending Physician Name	X(26)	L	86	111
9	Operating Physician Name	X(26)	L	112	137
10	Other Physician Name	X(26)	L	138	163
11	Other Physician Name	X(26)	L	164	189
12	Filler	X(3)	L	190	192

RECORD TYPE 90 - CLAIM SCREEN

- **May be preceded by RT 50 - 5N, 60 - 6N, 70 - 7N, or 80 - 8N.**
- **Must be followed by RT 20 or 95.**

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Screen = '90'	90	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record Type '90'	XX	L	1	2
2	Filler	XX	L	3	4
3	Patient Control Number	X(17)	L	5	21
4	Physical Record Count (Excluding Screen)	999	R	22	24
	Record Type nn Count (Fields 5-11)				
5	Record Type 2n Count	99	R	25	26
6	Record Type 3n Count	99	R	27	28
7	Record Type 4n Count	99	R	29	30
8	Record Type 5n Count	99	R	31	32
9	Record Type 6n Count	99	R	33	34
10	Record Type 7n Count	99	R	35	36
11	Record Type 8n Count	99	R	37	38
12	Total Days/Visits	9(4)	R	39	42
13	Total Charges - Accommodations	S9(6)V99	R	43	50
14	Non-Covered Charges - Accommodations	S9(6)V99	R	51	58
15	Total Charges - Ancillaries	S9(6)V99	R	59	66
16	Non-Covered Charges - Ancillaries	S9(6)V99	R	67	74
17	Remarks	X(118)	L	75	192

RECORD TYPE 95 - PROVIDER BATCH CONTROL

- **Must be preceded by RT 90.**
- **Must be followed by RT 10 or 99.**

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Batch Control	95	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION FROM	POSITION THRU
1	Record Type '95'	XX	L	1	2
2	Federal Tax Number	9(9)	L	3	11
3	Receiver Identification	9(5)	L	12	16
4	Receiver Sub-Identification	X(4)	L	17	20
5	Type of Batch	XXX	L	21	23
6	Number of Claims	9(5)	R	24	28
7	Total Days/Visits	9(5)	R	29	33
8	Accommodations Total Charges for the Batch	S9(6)V99	R	34	41
9	Accommodations Non-Covered Charges for the Batch	S9(6)V99	R	42	49
10	Ancillary Total Charges for the Batch	S9(6)V99	R	50	57
11	Ancillary Non-Covered Charges for the Batch	S9(6)V99	R	58	65
12	Filler (Reserved for National Use)	X(64)	L	66	129
13	Filler (Reserved for Local Use)	X(63)		130	192

RECORD TYPE 99 - TAPE CONTROL

- **Must be preceded by RT 95.**
- **Must be last valid record on tape.**

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Tape Control	99	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION	
				FROM	THRU
1	Record Type '99'	XX	L	1	2
2	Submitter EIN	9(9)	L	3	11
3	Receiver Identification	9(5)	L	12	16
4	Receiver Sub-Identification	X(4)	L	17	20
5	Number of Batches Billed this Tape	9999	R	21	24
6	Accommodations Total Charges for the Tape	S9(8)V99	R	25	34
7	Accommodations Non-Covered Charges for the Tape	S9(8)V99	R	35	44
8	Ancillary Total Charges for the Tape	S9(8)V99	R	45	54
9	Ancillary Non-Covered Charges for the Tape	S9(8)V99	R	55	64
10	Filler (Reserved for National Use)	X(65)		65	129
11	Filler (Reserved for Local Use)	X(63)		130	192

ADDENDUM B - ALPHABETIC LISTING OF DATA ELEMENTS:

Data Element	Definition	Record	Field
Accident Hour	The hour when the accident occurred that necessitated medical treatment	20	12
* Accommodations Revenue Code	UB-82 revenue center code for the accommodation provided. Includes codes 10X through 21X.	50 Four additional iterations in related locations for record 50, fields 11 - 14.	4
* Accommodations Days	A numeric count of accommodations days in accordance with payer instructions. Includes UB-82 revenue codes 10X through 21X.	50 Four additional iterations in related locations for record 50, fields 11 -14.	7
* Accommodations Non-covered Charges	Accommodations charges pertaining to the related UB-82 accommodations revenue code that are covered by the primary payer as determined by the provider.	50 Four additional iterations in related locations for record 50, fields 11 -14.	9
Accommodations Non-covered Charges for the Batch	Sum of charges recorded in related field in record type 90, field 14	95	9
* Accommodations Rate	Per diem rate for related UB-82 accommodations revenue code.	50 Four additional iterations in related locations for record 50, fields 11 - 14.	6
* Accommodations Total Charges	Total charges for the related revenue code.	50	8
Accommodations Total Charges for the Batch	Total accommodation charges for this batch	95	8

* Complete for Medicare

Data Element	Definition	Record	Field
* Admission Date	The date the patient was admitted to the provider for inpatient care, outpatient service or start of care. For an admission notice for hospice care enter the effective date of election of hospice benefits.	20	18
Admission Hour	The hour during which the patient was admitted for inpatient or outpatient care.	20	19
Ancillary Date of Service	The date the associated ancillary service as identified by the UB-82 revenue center code was delivered.	60 Four additional iterations in related locations for record 60, fields 12 - 154.	6
Ancillary Non-Covered Charges	Charges pertaining to the related UB-82 ancillary revenue center code that the primary payer will not cover.	60 Four additional iterations in related locations for record 60, fields 12 - 15.	9
Ancillary Non-Covered Charges for the Batch	Sum of charges recorded in related field, record type 90, field 16.	95	11
*Ancillary Revenue Code	UB-82 revenue center code for the ancillary services provided. Includes codes 22X through 99X.	60 Four additional iterations in related locations for record 60, fields 12 - 15.	4
* Ancillary Total Charges	Total charges pertaining to the related UB-82 ancillary revenue center code. (And date, if applicable.)	60	8
Ancillary Total Charges for the Batch	Total ancillary charges for this batch	95	10

* Complete for Medicare

Data Element	Definition	Record	Field
* Ancillary Units of Service	A quantitative measure of services rendered by UB-82 revenue center category to or for the patient to include such items as number of miles, pints of blood, number of renal dialysis treatments, etc.	60 Four additional iterations in related locations for record 60, fields 12 - 15.	7
Assignment of Benefits Certification Indicator	A code showing whether the provider has a signed form authorizing the third party payer to pay the provider. Y=Benefits assigned N=Benefits not assigned	30	16
Attending Physician Name	Name of the licensed physician who would normally be expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment	80	8
* Attending Physician Number	Number assigned to identify physician named in Record 80, field 8	80	4
* Batch Number	Number assigned by the provider sequentially from 01 to nn to each batch of bills of a given type.	10	3
* Blood-Deductible Pints	The number of unreplaced pints of whole blood or units of packed red cells furnished for which the patient is responsible.	40	13
* Blood-Furnished Pints	Total number of pints of whole blood or units of packed red cells furnished to the patient.	40	10
* Blood-Replaced Pints	The total number of pints of whole blood or units of packed red cells furnished to the patient that have been replaced by or on behalf of the patient.	40	11
* Blood-Unreplaced Pints	The number of pints of whole blood or units of packed red cells furnished to the patient that have not been replaced by or on behalf of the patient.	40	12
Blue Cross/Blue Shield Provider Number	The number assigned to the provider by Blue Cross.	10	10

* Complete for Medicare

Data Element	Definition	Record	Field
* Certificate/ Social Security Number/Health Insurance Claim/ Identification Number	Insured's unique identification number assigned by the payer organization. Medicare: Enter the patient's Medicare HIC number as on the Health Insurance Card, Certificate of Award, Utilization Notice, Temporary Eligibility Notice, Hospital Transfer Form, or as reported by the Social Security Office.	30	7
* Co-Insurance	That amount assumed by the hospital to be applied toward the patient's coinsurance amount involving the indicated payer.	30	24
* Coinsurance Days	The inpatient Medicare days occurring after the 60th day and before the 91st day in a single spell of illness.	30	21
* Condition Codes	A code(s) used to identify conditions relating to this bill that may affect payer processing (Addendum C).	40	27-31
* Covered Days	The number of days covered by the primary payer, as qualified by the payer organization.	30	19
* Deductible	That amount assumed by the hospital to be applied to the patient's deductible amount involving the indicated payer.	30	23
Discharge Hour	Hour that the patient was discharged from inpatient care. (Addendum C)	20	23
* Employee ID Number	The identification number assigned by the employer to the insured identified in record 30, fields 11 - 13 as qualified by the payer organization, or as applicable, to the individual indicated by the employment info. code in record 21, field 10, or field 18.	21 31	9&17 14
* Employer Location	The specific location for the employer of the individual identified in record 30.	21 21 31	5-8 13-16 10-13

* Complete for Medicare

Data Element	Definition	Record	Field
* Employer Name	The name of the employer that might or does provide health care coverage for the individual identified in record 30.	21 21 31	4 12 9
* Employment Information Data	A code that indicates whether the employment information given in the related area applies to the patient, the patient's spouse, the patient's mother, or the patient's father. (See Addendum C)	21 21	10 18
Employment Status Code	A code used to define the employment status of the individual identified by the "Employment Information Data" code, or by name in record 30. (See Addendum C).	21 21 30	11 19 18
Estimated Amount Due	The amount estimated by the hospital to be due from the indicated payer. (Estimated responsibility less prior payments.)	30	25
Estimated Responsibility	The amount estimated by the hospital to be paid by the indicated payer.	30	26
Federal Tax Number	The number assigned to the provider by the federal government for tax reports purposes. Also known as a tax identification number (TIN) or employer identification number (EIN).	10 95	4 2
Insurance Group Number	The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.	30	9
* Insured Address	Insured's current mailing address.	31	4 - 8
	Address Line 1	31	4
	Address Line 2	31	5
	City	31	6
	State	31	7
	Zip	31	8
Insured Group Name	Name of the group or plan through which the insurance is provided to the insured.	30	10
Insured's Name	Name of the individual in whose name the insurance is carried.	30	11-13
	Last Name	30	11
	First Name	30	12
	Middle Initial	30	13

* Complete for Medicare

Data Element	Definition	Record	Field
* Insured's Sex	A code indicating the sex of the insured. M=Male F=Female U=Unknown	30	14
* Lifetime Reserve Days	Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.	30	22
* Medicaid Provider Number	The number assigned to the provider by Medicaid.	10	8
* Medical Record Number	Number assigned to patient by hospital or other provider to assist in retrieval of medical records	20	25
* Medicare Provider Number	The number assigned to the provider by Medicare.	10	6
* Multiple Provider Billing Tape Indicator	A code indicating whether bills for more than one provider are contained on this tape submission, according to the following coding scheme. 1=Single Provider 2=Multiple Providers	01	3
Non-Covered Charges - Accommodations	Total of accommodation charges not covered by primary payer for this bill as reflected in record type 50, field 9 and subsequent accommodation packets in record type 50.	90	14
* Non-Covered Charges - Ancillaries	Total of "Ancillary Charges-Noncovered" for this bill as reflected in record type 60, field 9.	90	16
* Non-Covered Days	Days of care not covered by the primary payer.	30	20
* Number of Claims	A count of the number of record type 20 entries for this provider batch. (record type 10 to record type 95)	95	6
* Number of Batches Billed this Tape.	A count of the number of batches billed on this tape or transmission.	99	5

* Complete for Medicare

Data Element	Definition	Record	Field
* Number of Grace Days	Following the date of the PSRO/UR denial determination, this is the number of days determined by the PSRO/UR to be necessary to arrange for the patient's post discharge care.	40	8
* Occurrence Code	A code defining a significant event relating to this bill that may affect payer processing. (See Addendum C).	40	14, 16 18, 20 22
	Occurrence Code 1	40	14
	Occurrence Code 2	40	16
	Occurrence Code 3	40	18
	Occurrence Code 4	40	20
	Occurrence Code 5	40	22
* Occurrence Date	Date associated with the Occurrence Code in the preceding field.	40	15, 17 19, 21 23
	Occurrence Date 1	40	15
	Occurrence Date 2	40	17
	Occurrence Date 3	40	19
	Occurrence Date 4	40	21
	Occurrence Date 5	40	23
* Occurrence Span Code - 1	A code that identifies an event that relates to the payment of the claim. (See Addendum C)	40	24
* Occurrence Span Date - 1	The dates related to the Occurrence Span Code shown in the preceding field.	40	25&26
Operating Physician Name	Name used by the provider to identify the operating physician in the provider records.	80	9
* Operating Physician Number	Number used by the provider to identify the operating physician in the provider records.	80	5
* Other Diagnosis Codes	The ICD-9-CM diagnoses codes corresponding to additional conditions that co-exist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay.	70	5-8
Other Physician ID NAME/NUMBER	The name and/or number of the licensed physician other than the attending physician as defined by the payer organization.	80	6,7, 10&11

* Complete for Medicare

Data Element	Definition	Record	Field
* Other Procedure Codes	The codes identifying the procedures, other than the principal procedure, performed during the billing period covered by this bill.	70	12, 15
* Other Procedure Dates	Date that the procedure indicated by the related code (preceding field) was performed	70	14, 17
* Patient Address	The address of the patient as qualified by the payer organization.	20	13-17
	Line 1		13
	Line 2		14
	City		15
	State (P.O. Code)		16
	Zip		17
* Patient Birthdate	The date of birth of the patient. Includes 4 pos. Year. (MMDDYYYY).	20	9
* Patient Control Number	Patient's unique alpha-numeric number assigned by the provider to facilitate retrieval of individual case records and posting of payment.	20-90	3
* Patient Has Paid	Amount patient has paid to the provider towards this bill.	20	24
Patient Marital Status	The marital status of the patient at date of admission, outpatient service, or start of care. (See Addendum C).	20	12
* Patient Name	Last name, first name, and middle initial of the patient.	20	4 - 6
	Last name	20	4
	First name	20	5
	Middle Initial	20	6
* Patient's Relationship to Insured	A code indicating the relationship of the patient to the identified insured. (See Addendum C).	30	17
* Patient Sex	The sex of the patient as recorded at date of admission, outpatient service, or start of care. M=Male F=Female U=Unknown	20	7

* Complete for Medicare

Data Element	Definition	Record	Field
* Patient Status	A code indicating patient status as of the statement covers thru date. (See Addendum C).	20	22
* Physical Record Count (Excluding Screen)	The total number of physical records submitted for this bill, including all record types 20 through 8n, and excluding record type 90.	90	4
* Payer Identification	Number identifying each payer organization from which the provider might expect some payment for the bill. (See Addendum C).	30	5
* Payer Name	Name identifying each payer organization from which the provider might expect some payment for the bill.	30	8
Payer Sub-identification	The identification of the specific office within the insurance carrier designated as responsible for this claim.	30	6
* Primary Payer Code	Identifies reason another payer is primary to Medicare. (See Addendum C).	30	28
* Principal and Other Diagnoses Descriptions	Narrative description of the principal diagnosis (i.e., the condition established after study to be chiefly responsible for causing the hospitalization or use of hospital services) and other diagnoses. ICD-9-CM terminology should be used.	70	19
* Principal Diagnosis Code	The ICD-9-CM diagnosis codes describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for causing this hospitalization).	70	4
* Principal Procedure Code	The code that identifies the principal procedure performed during the period covered by this bill.	70	9
* Principal Procedure Date	The date on which the principal procedure described on the bill was performed.	70	11

* Complete for Medicare

Data Element	Definition	Record	Field
* Principal and Other Procedures Descriptions	A narrative description of the principal procedure (i.e., the procedure that was performed for definitive treatment rather than the one performed for diagnostic or exploratory purposes or the procedure most related to the principal diagnosis) and other procedures. The principal procedure is to be shown first.	70	20
* Prior Payments - Payer and Patients	The amount the hospital has received toward payment of this bill prior to the billing date by the indicated payer.	30	27
Procedure Code	Procedure code reported in type 61 record to identify physician services so that reimbursement can be made as though the service had been provided in the physician's office.	61	4
Procedure Coding Method Used	An indicator that identifies the coding method used for procedure coding on the bill. (See Addendum C).	10	18
* Processing date ("Date Bill Submitted" on HCFA-1450).	Date submitter prepares file.	01	8
* Provider Address	Complete mailing address to which the provider wishes payment sent.	10	14-17
	Street address or box number	10	14
	City	10	15
	State (P.O. abbreviations)	10	16
	Zip	10	17
* Provider Name	Name of provider submitting this batch of bills.	10	13
Provider Telephone Number	Telephone number, including area code, at which the provider wishes to be contacted for claims development.	10	12
* PSRO/PRO Approval Indicator	An indicator describing the determination arrived at by the PRO or PSRO.	40	5

* Complete for Medicare

Data Element	Definition	Record	Field
* PSRO/PRO Approved Stay Dates	The first and last days that were approved where not all of the stay has been approved by the PRO or PSRO.	40	6 - 7
* Receiver Identification	Number identifying to the provider the organization designated to receive this file. (See Addendum C).	01 95 99	6 3 3
Receiver Sub-Identification	The identification of the specific location within the receiver organization designated to receive the tape or transmission.	01 95 99	7 4 4
* Receiver Type Code	A code indicating the class of organization designated to receive this tape or transmission. (See Addendum C).	01	5
* Record Type nn Count	A count of record types 20-2n through 80-8n, fields 5 through 11 of this record. These fields should crossfoot to the total in field 4 of this record.	90	5 -11
* Reel Sequence Number	Sequence number from 01 to nn assigned to each reel in this file of records.	01	15
Reel Serial Number	Inventory number of the reel.	01	16
* Remarks	Notations relating specific state and local needs providing additional information necessary to adjudicate the claim or otherwise fulfill state reporting requirements.	90	17
* Release of Information Certification Indicator	A code indicating whether the provider has on file a signed statement permitting the payer to release data to other organizations in order to adjudicate the claim. (See Addendum C).	30	15

* Complete for Medicare

Data Element	Definition	Record	Field
* Sequence Number	Sequential number from 01 to nn assigned to individual records within the same specific record type code to indicate the sequence of the physical record within the record type. Records 20-2n, 40-4n, 70-7n and 80-8n will never have a sequence number greater than 01. The sequence number for record types 30 and 31 are used as matching criteria to determine which type 30 and type 31 records are associated, like sequence numbers indicating the records are associated.	30-3n 50-5n 60-6n	2 2 2
* Source of Admission	A code indicating the source of this admission. (See Addendum C).	20	11
* Source of Payment Code	A code indicating source of payment associated with this payer record. (See Addendum C).	30	4
* Special Program Indicator	A code indicating that the services included on this bill are related to a special program. (See Addendum C).	31	16
* Statement Covers Period	The beginning and ending service dates of the period covered by this bill.	20	20-21
* Submitter Address	Mailing address of the submitter of this file.	01	10-13
	Address		10
	City		11
	State		12
	Zip		13
* Submitter EIN	Federally assigned Employer Identification Number (EIN) of tape submitter. EIN is also referred to as Tax Identification Number (TIN).	1 99	2 2

* Complete for Medicare

Data Element	Definition	Record	Field
* Submitter Name	Name of provider, third party billing service, or other organization to which the receiver/ processor should direct inquiries regarding this transmittal.	01	9
Submitter Telephone Number	Telephone number, including area code, at which the submitter wishes to be contacted for claim development.	01	14
* Total Days/Visits	Inpatient bills: the sum of all days reported in accommodation packets in record type 50. Outpatient and home health bills: the sum of all visits recorded as "units of service" for this bill record in record type 60, field 7.	90	12
	Sum of days/visits recorded in record type 90, field 12.	95	7
* Treatment Authorization Code	A number or other indicator that designates that the treatment covered by this bill has been authorized by the payer.	40	9
* Total Charges - Accommodations	Total accommodation charges for this bill	90	13
Total Charges - Ancillaries	Total ancillary charges for this bill	90	15
* Type of Admission	A code indicating the priority of this admission. (See Addendum C).	20	10

* Complete for Medicare

Data Element	Definition	Record	Field
* Type of Batch	A code indicating the types of bills that occur in this batch; i.e. between a provider record (record type 10), and a provider batch control (record type 95). (See Addendum C).	10 95	2 5
* Type of Bill	A code indicating the specific type of bill (inpatient, outpatient, adjustments, voids, etc.) (See Addendum C).	40	4
* Value Amount	Amount of money related to the associated value code. (See Addendum C for Value Codes).	40	32, 34, 36, 38 40, 42 44&46
* Value Code	A code that identifies data of a monetary nature that is necessary for processing this claim as qualified by the payer organization. (See Addendum C).	40	33, 35 37, 39 41, 43 45&47
* Version Code	A code that indicates the version of the National Specifications submitted on this reel, disk, etc. 001 = UB-82 data set as finally approved 08/17/82.	01	19

* Complete for Medicare

ADDENDUM C - CODING STRUCTURES

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Data Element: Accident Hour

Definition: The hour when the accident occurred that necessitated medical treatment.

00 - 23; Midnight (12:00-12:59) = 00
01:00-01:59 AM = 01

Noon (12:00-12:59) = 12
01:00-01:59 PM = 13

11:00-11:59 PM = 23
99 = UNKNOWN

Data Element: Admission Hour

Definition: The hour during which the patient was admitted for inpatient or outpatient care.

00 - 23; Midnight (12:00-12:59) = 00
01:00-01:59 AM = 01

Noon (12:00-12:59) = 12
01:00-01:59 PM = 13

11:00-11:59 PM = 23
99 = UNKNOWN

Data Element: Condition Codes

Data Definition: A Code(s) used to identify conditions relating to this bill that may affect payer processing.

Code Structure:

Code	Code Title	Definition
INSURANCE CODES		
01	Military Service Related	Medical condition incurred during military service.
02	Condition is Employment Related	Patient alleges that medical condition is due to environment/events resulting from employment.
03	Patient Covered by Insurance not Reflected Here	Indicates that patient/patient representative has stated that coverage may exist beyond that reflected on this bill.
04	HMO Enrollee	Medicare beneficiary is enrolled in an HMO.
05	Lien has been filed	Provider has filed legal claim for recovery of funds potentially due a patient as a result of legal action initiated by or on behalf of the patient.
06	ESRD Patient in first year of entitlement covered by employer group health insurance	Code indicates Medicare may be a secondary insurer if the patient is also covered by employer group health insurance during his first year of end stage renal disease entitlement.
07	Treatment of non-terminal condition for hospice patient.	The patient is a hospice enrollee, but the provider is not treating his terminal condition and is therefore requesting Medicare reimbursement.
08-16		Reserved for National assignment.
SPECIAL CONDITIONS		
17	Patient is Over 100 years old	Indicates that the patient is over 100 years old at date of admission or outpatient services. Not used for electronic billing.
18	Maiden Name Retained	A dependent spouse entitled to benefits who does not use her husband's last name.

19	Child Retains Mother's Name	A patient who is a dependent child entitled to CHAMPUS or CHAMPVA benefits that does not have his father's last name.
20-30		Reserved for national assignment

STUDENT STATUS (Required when patient is a dependent child over 18 years old)

Note: Use only one of the following codes - lowest code value number takes precedence.

31	Patient is student (full time - day)	Patient declares that he or she is enrolled as a full time day student.
32	Patient is student (Cooperative/work study program)	Self Explanatory
33	Patient is student (full time - night)	Patient declares that he or she is enrolled as a full time night student.
34	Patient is student (part time)	Patient declares that he or she is enrolled as a part time student.
35		Reserved for National Assignment.

ACCOMMODATIONS

36	General care patient in a special unit	Patient temporarily placed in special care unit bed because no general care beds available.
37	Ward Accommodation-Patient's Request	Patient assigned to ward accommodations at patient's request.
38	Semi-Private Room Not Available	Indicates that either private or ward accommodations assigned because semi-private accommodations were not available.
39	Private Room Medically Necessary	Patient needs a private room for medical requirements.
40	Same Day Transfer	Patient transferred to another facility before midnight on the day of admission.
40-45		Reserved for National Assignment

CHAMPUS INFORMATION

46	Non-Availability Statement on File	A nonavailability statement must be be on file for each CHAMPUS claim for non emergency inpatient care when the CHAMPUS beneficiary resides within the catchment area (usually a 40 mile radius) of a Uniform Services Hospital.
47		Reserved for CHAMPUS
48-59		Reserved for National Assignment.

PROSPECTIVE PAYMENT

60	Day Outlier	A hospital being paid under a prospective payment system is reporting this stay as a day outlier
61	Cost Outlier	A hospital being paid under a prospective payment system is requesting additional payment for this stay as a cost outlier
62	Payer Code	PROVIDERS DO NOT REPORT THIS. FOR PAYER INTERNAL USE ONLY. Indicates the claim was paid under a DRG.
63-70		Reserved for National Assignment

RENAL DIALYSIS SETTING

71	Full Care In Unit	Billing is for a patient who received staff assisted dialysis services in a hospital or renal dialysis facility.
72	Self Care in Unit	Billing is for a patient who managed his own dialysis services without staff assistance in a hospital or renal dialysis facility.
73	Self Care Training	Billing is for special dialysis services where a patient and his helper (if necessary) were learning to perform dialysis.
74	Home	Billing is for a patient who received dialysis services at home but where code 75 below does not apply.
75	Home - 100 Percent Reimbursement	Billing is for a patient who received dialysis services at home, using a dialysis machine that was purchased by Medicare under the 100 percent program.

76	Back-up Facility	Billing is for a patient who received dialysis services in a back-up facility.
77-79		Reserved for National Assignment.
80-99		Reserved for State Assignment.

Data Element: Discharge hour

Definition: Hour that the patient was discharged from inpatient care:

00 - 23;
Midnight (12:00-12:59) = 00
01:00-01:59 AM = 01
Noon (12:00-12:59) = 12
01:00-01:59 PM = 13
11:00-11:59 PM = 23
99 = UNKNOWN

Data Element: Employment Information Data.

Definition: A code that indicates whether the employment information given in the related areas applies to an insured, the patient or the patient's spouse.

Code Structure:
P - Patient Employment Information.
S - Spouse Employment Information.
F - Father's Employment Information.
M - Mother's Employment Information.

Data Element: Employment Status Code.

Definition: A code used to define the employment status of the individual identified by the "Employment Information Data" code.

Code	Code Title	Definition
1	Employed full time	Individual states that he or she is employed full time.
2	Employed part time	Individual states that he or she is employed part time.
3	Not employed	Individual states that he or she is not employed full time or part time.
4	Self Employed	Self-explanatory.
5	Retired	Self-explanatory.
6	On Active Military Duty	Self-explanatory.
7-8		Reserved for National assignment.
9	Unknown	Individual's employment status is unknown.

Data Element: Occurrence code.

Definition: A code defining a significant event relating to this bill that may affect payer processing.

ACCIDENT RELATED CODES

01	Auto Accident	Code indicating the date of an auto accident.
02	Auto Accident/ No Fault Insurance Involved	Code indicating the date of an accident where state has applicable no fault liability laws. (i.e., legal basis for settlement without admission or proof of guilt).
03	Accident/Tort Liability	Code indicating the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no fault liability. This date could also be the date of an event for which a third party makes a nonjudical admission of liability. Medicare would become secondary payer in this case.
04	Accident/Employment Related	Code indicating the date of an accident allegedly relating to the patient's employment.
05	Other Accident	Code indicating the date of an accident not described by the above codes.
06	Crime Victim	Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.
07-09		Reserved for National Assignment.

MEDICAL CONDITION CODES

10	Last Menstrual Period	Code indicating the date of the last menstrual period; ONLY applies when patient is being treated for maternity-related condition.
11	Onset of Symptoms/Illness	Date the patient first became aware of symptoms/illness.
12-19		Reserved for National Assignment.

INSURANCE RELATED CODES

20	Guarantee of Payment Began	Code indicating the date on which the provider began claiming Medicare payment under the guarantee of payment provision.
21	UR/PSRO Notice Received	Code indicating the date of receipt by the hospital of the UR Committee's (PSRO or other responsible group's) finding that an admission or further stay was not medically necessary
22	Active Care Ended	Code indicating the date on which a covered level of care ended in a general hospital, or date on which active care ended in a psychiatric or tuberculosis hospital. Code not required where PSRO/UR approval is completed.
23	Benefits Exhausted	Code indicating the last date for which benefits are being claimed by the provider.
24	Date Insurance Denied	Code indicating the date the denial of coverage was received by the hospital from the insurer.
25	Date Benefits Terminated By Primary Payer	The date on which coverage (including Worker's Compensation benefits or no-fault coverage) is no longer available to the patient.
26	Date SNF Bed Available	Code indicating the date on which a SNF bed became available to hospital inpatient who requires only SNF level care.
27	Date Home Health Plan Established	Code indicating the date a home health plan of treatment was established (THIS CODE IS ONLY TO BE USED BY HOME HEALTH PROVIDERS),
28-39		Reserved for National Assignment.

SERVICE RELATED CODES

40	Scheduled Date of Admission	The date on which a patient will be admitted as an inpatient to the hospital. (This code may only be used on an outpatient claim.)
41	Date of First Test for Pre-Admission Testing	The date on which the first outpatient diagnostic test was performed as part of a PAT program. This code may only be used if a date of admission was scheduled prior to the administration of the test(s).
42	Date of Discharge	To be used when "Through" date in "Statement Covers Period" is not the actual discharge date and the frequency code in the "Type of Bill" code is that of a final bill. For final bill for hospice care, enter the date the Medicare beneficiary terminated his election of hospice care.
43 -49		Reserved for National Assignment.
50-69		Reserved for State Assignment.
70-99		See Occurrence Span Codes. If this code is encountered in an Occurrence Code field, the date following is the "From Date" of the date span, the next Occurrence Code field must be blank, and the next date field is the "Through Date" of the date span.

Data Element: Occurrence Span Code-1.

Data Definition: A code that identifies an event that relates to the payment of the claim.

Code Structure

70	Qualifying Stay Dates (Medicare)	The from/thru date of at least a 3-day hospital stay that qualifies the patient for Medicare payment of SNF services billed. Code can be used only by SNF for billing.
71	Prior Stay Dates	The from/thru dates given by the patient of any hospital, SNF, or nursing home stay that ended within 60 days of this hospital or SNF admission.
72	First/Last Visit	The from/through dates of outpatient services. For use on outpatient bills only where the entire billing record is not represented by the actual from/through service dates shown in the "Statement Covers Period".
73	Benefit Eligibility Period	The inclusive dates during which CHAMPUS medical benefits are available to a sponsor's beneficiary as shown on the beneficiary's ID card.
74	Noncovered Level of Care	The from/through dates of a period at a noncovered level of care in an otherwise covered stay.
75	SNF Level of Care	The from/through dates of a period of SNF level of care during an inpatient hospital stay. Used to show PSRO/PRO approval of patient's remaining in hospital because SNF bed not available. Code is not applicable to Swing Bed cases. For hospitals under prospective payment, this code is needed in day outlier cases only.
76-79		Reserved for National Assignment.
80-99		Reserved for State Assignment.

Data Element: Patient Marital Status.

Definition: The marital status of the patient at date of admission, outpatient service, or start of care:

S - Single
M - Married
X - Legally Separated
D - Divorced
W - Widowed
U - Unknown

Data Element: Patient's Relationship to Insured.

Definition: A code indicating the relationship of the patient to the identified insured:

01	Patient Is Insured	Self - explanatory
02	Spouse	Self - explanatory
03	Natural Child/ Insured has financial responsibility	Self - explanatory
04	Natural Child/ Insured does not have financial responsibility	Self - explanatory
05	Step Child	Self - explanatory
06	Foster Child	Self - explanatory
07	Ward of the Court	Patient is ward of insured as a result of a court order.
08	Employee	Patient is employed by the insured.
09	Unknown	Patient's relationship to the insured is unknown.
10	Handicapped dependent	Dependent child whose coverage extends beyond normal termination age limits as result of laws or agreements extending coverage.
11	Organ donor	Code is used in cases where bill is submitted for care given to organ donor where such care is paid by the receiving patient's insurance coverage.
12	Cadaver donor	Code is used where bill is submitted for procedures performed on cadaver donor where such procedures are paid by the receiving patient's insurance coverage.
13	Grandchild	Self - explanatory
14	Niece/Nephew	Self - explanatory
15	Injured Plaintiff	Patient is claiming insurance as a result of injury covered by insured.
16	Sponsored dependent	Individual not normally covered by insurance coverage but coverage has been specially arranged to include relationships such as grandparent or former spouse that would require further investigation by the payer.
17	Minor Dependent of a Minor Dependent	Patient is a minor, and the dependent of a minor that is in turn, a dependent but not the child of the insured.
18	Parent	Self explanatory
19	Grandparent	Self explanatory
20 -99		Reserved for National Assignment

Data Element: Patient status.

Definition: A code indicating patient status as of statement covers thru date:

Codes:

01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another short-term general hospital
03	Discharged/transferred to skilled nursing facility (SNF)
04	Discharged/transferred to an intermediate care facility (ICF)
05	Discharged/transferred to another type of institution
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice
08 -09	Reserved for National Assignment
10 -19	Discharge to be defined at State level, if necessary
20	Expired - (or did not recover - Christian Science Patient)
21 -29	Expired to be defined at State level, if necessary
30	Still patient
31 -39	Still patient to be defined at State level, if necessary
40	Expired at home
41	Expired in a hospital, SNF, or ICF
42	Expired - place unknown
43 -99	Reserved for National Assignment

Data Element: Payer Identification.

Definition: Number identifying each payer organization from which the provider might expect some reimbursement for the bill.

Blue Cross - The Blue Cross number (oonnn)
Commerical Insurers - NAIC assigned number (nnnnn)
Medicaid - State Agency assigned number
Medicare - One or two above, depending on intermediary
CHAMPUS - NAIC number

Data Element: Primary Payer Code.

Definition: Identifies reason another payer is primary to Medicare.

Codes:

Z	Medicare is Primary
A	Working Aged Bene/Spouse with Employer Group Health Plan
B	ESRD Bene in 12 month period with Employer Group Health Insurance
C	Any conditional payment situation
D	Automobile No-Fault or any liability insurance
E	Worker's Compensation, including Black Lung
F	VA, PHS, Other Federal Agency

Data Element: Procedure Coding Method Used.

Definition: An indicator that identifies the coding method used for procedure coding on the bill.

1 -3 - Reserved for State and Local Assignment
4 - CPT-4
5 - HCPCS (HCFA Common Procedure Coding System)
6 -8 - Reserved for National Assignment
9 - ICD-9-CM

Data Element: PSRO/PRO Approval Indicator.

Definition: An indicator describing the determination arrived at by the PSRO, or PRO.

Code 1	Approved as Billed	Code indicates claim has been reviewed by a PSRO or PRO and has been approved as billed. If the claim is from a hospital being reimbursed under the Prospective Payment System, this code also indicates the PSRO/PRO has approved any length of stay or cost outlier occurring during the stay.
2	Automatic Approval (Focused Review)	Code indicates claim has not been reviewed by a PSRO or PRO but has automatic approval as billed since it does not fall into a focused review category.
3	Partial Approval	Code indicates the bill has been reviewed by a PSRO or PRO and has been only partially approved; i.e., it contains some services which have been determined to be noncovered. If the claim is from a hospital being reimbursed by Medicare under the Prospective Payment System, this code also indicates the PSRO/PRO has considered, but not fully approved any length of stay or cost outlier occurring during the stay. The from/through dates of the approved portion of the stay, excluding grace days, and any period at a noncovered level of care is shown in items 88 and 89 of the HCFA-1450.
4	Admission Denied	Code indicates patient's need for hospitalization was reviewed upon admission and the PSRO or PRO found that none of the stay was medically necessary.
5	Post-payment review Applicable	code indicates that any PSRO/PRO review will be completed after the claim is paid. The bill may be day outlier or part of the sample review, may be reviewed for other reasons, or may not be reviewed.
6-9		Reserved for National Assignment.

Data Element: Receiver Identification

Definition: Number identifying to the provider the organization designated to receive this file. Receivers accepting tapes on behalf of more than one third party payer are to be identified by their tax

Data Element: Receiver Type

Definition: A code indicating the class of organization designated to receive this tape or transmittion.

A - Self pay
B - Workers Compensation
C - Medicare
D - Medicaid
E - Other Federal program
F - Insurance company
G - Blue Cross
H - CHAMPUS
I - Other - local coding table applies
Z - Multiple principal
Sources of payment 1/

Data Element: Release of Information Certification Indicator

Definition: A code indicating whether the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim.

Codes:

Y-Yes	The hospital has signed written authority to release medical/billing information for purposes of claiming insurance benefits.
R-Restricted or Modified Release	The hospital has limited or restricted authority to release some medical/billing information for purposes of claiming insurance benefits.
N-No Release	The hospital does not have permission to release any medical/billing information.

Data Element: Revenue Code

Definition: A Code which identifies a specific accommodation, ancillary service or billing calculation.

Code Structure:

Major Category

PAYER AND RELATED INFORMATION (codes 001 - 099).

N.B.: THESE CODES SHOULD BE REPORTED IN RECORD TYPE 60, BUT THE AMOUNTS ASSOCIATED WITH THEM SHOULD NOT BE INCLUDED IN CONTROL TOTALS MAINTAINED IN RECORD TYPES 90 THRU 9N.

Rationale: To group items by payer and to assign similar items the same number.

001 Total Charge

01X to 06X Reserved for National Assignment

07X to 09X Reserved for State Use

ACCOMMODATION REVENUE CODES (10X - 21X)

10X All Inclusive Rate

Flat fee charge incurred on either a daily basis or total stay basis for services rendered. Charge may cover room and board plus ancillary services or room and board only.

	Subcategory	Standard Abbreviations
0	All-Inclusive Room and Board Plus Ancillary	ALL INCL R&B/ANC
1	All-Inclusive Room and Board	ALL INCL R&B

READEX FICHE

11X **Room & Board - Private Medical or General**

Routine service charges for single bed rooms.

Rationale: Most third party payers require that private rooms be separately identified.

Subcategory	Standard Abbreviation
0 - General Classification	ROOM-BOARD/PVT
1 - Medical/Surgical/Gyn	MED-SUR-GY/PVT
2 - OB	OB/PVT
3 - Pediatric	PEDS/PVT
4 - Psychiatric	PSYCH/PVT
5 - Hospice	HOSPICE/PVT
6 - Detoxification	DETOX/PVT
7 - Oncology	ONCOLOGY/PVT
9 - Other	OTHER/PVT

12X **Room & Board - Semi-private Two Bed (Medical or General)**

Routine service charges incurred for accommodations with two beds.

Rationale: Most third party payers require that semi-private rooms be identified.

Room and Board - Semi-Private

Subcategory	Standard Abbreviation
0 - General Classification	ROOM-BOARD/SEMI
1 - Medical/Surgical/Gyn	MED-SUR-GY/2BED
2 - OB	OB/2BED
3 - Pediatric	PEDS/2BED
4 - Psychiatric	PSYCH/2BED
5 - Hospice	HOSPICE/2BED
6 - Detoxification	DETOX/2BED
7 - Oncology	ONCOLOGY/2BED
9 - Other	OTHER/2BED

13X Semi-Private - Three and Four Beds

Routine service charges incurred for accommodations with three and four beds.

Subcategory	Standard Abbreviation
0 - General Classification	ROOM-BOARD/3&4 BED
1 - Medical/Surgical/Gyn	MED-SUR-GY/3&4 BED
2 - OB	OB/3&4BED
3 - Pediatric	PEDS/3&4BED
4 - Psychiatric	PSYCH/3&4BED
5 - Hospice	HOSPICE/3&4BED
6 - Detoxification	DETOX/3&4BED
7 - Oncology	ONCOLOGY/3&4BED
9 - Other	OTHER/3&4BED

14X Private (Deluxe)

Deluxe rooms are accommodations with amenities substantially in excess of those provided to other patients.

Subcategory	Standard Abbreviation
0 - General Classification	ROOM-BOARD/PVT/DLX
1 - Medical/Surgical/Gyn	MED-SUR-GY/DLX
2 - OB	OB/DLX
3 - Pediatric	PEDS/DLX
4 - Psychiatric	PSYCH/DLX
5 - Hospice	HOSPICE/DLX
6 - Detoxification	DETOX/DLX
7 - Oncology	ONCOLOGY/DLX
9 - Other	OTHER/DLX

15X Room & Board Ward (Medical or General)

Routine service charge for accommodations with five or more beds.

Rationale: Most third party payers require ward accommodations to be identified.

Subcategory	Standard Abbreviation
0 - General Classification	ROOM-BOARD/WARD
1 - Medical/Surgical/Gyn	MED-SUR-GY/WARD
2 - OB	OB/WARD
3 - Pediatric	PEDS/WARD
4 - Psychiatric	PSYCH/WARD
5 - Hospice	HOSPICE/WARD
6 - Detoxification	DETOX/WARD
7 - Oncology	ONCOLOGY/WARD
9 - Other	OTHER/WARD

16X Other Room & Board

Any routine service charges for accommodations that cannot be included in the more specific revenue center codes.

Rationale: Provides the ability to identify services as required by payers or individual institutions.

Sterile environment is a room and board charge to be used by hospitals that are currently separating this charge for billing.

Subcategory	Standard Abbreviation
0 - General Classification	R&B
4 - Sterile Environment	R&B/STERILE
7 - Self Care	R&B/SELF
9 - Other	R&B/Other

17X Nursery

Charges for nursing care to newborn and premature infants in nurseries.

Rationale: Provides a breakdown of various levels of nursery care. Tertiary care is a level of care between premature and regular nursery care.

Subcategory	Standard Abbreviation
0 - General Classification	NURSERY
1 - Newborn	NURSERY/NEWBORN
2 - Premature	NURSERY/PREMIE
5 - NeoNatal ICU	NURSERY/ICU
9 - Other	NURSERY/OTHER

18X Leave of Absence

Charges (including zero charges) for holding a room while the patient is temporarily away from the provider.

Note: Charges are billable for codes 2 - 5

Subcategory	Standard Abbreviation
0 - General Classification	LEAVE OF ABSENCE OR LOA
2 - Patient Convenience - charges billable	LOA/PT CONV CHGS BILLABLE
3 - Theraputic Leave	LOA/THERAP
4 - ICF Mentally Retarded - any reason	LOA/ICF/MR
5 - Nursing Home (Hospitalization)	LOA/NURS HOME
9 - Other Leave of Absence	LOA/OTHER

19X Not Assigned

20X Intensive Care

Routine service charge for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit.

Rationale: Most third party payers require that charges for this service are to be identified.

Subcategory	Standard Abbreviation
0 - General Classification	INTENSIVE CARE or (ICU)
1 - Surgical	ICU/SURGICAL
2 - Medical	ICU/MEDICAL
3 - Pediatric	ICU/PEDS
4 - Psychiatric	ICU/PSTAY
6 - PRE/Post ICU	PRE/POST ICU
7 - Burn Care	ICU/BURN CARE
8 - Trauma	ICU/TRAMA
9 - Other Intensive Care	ICU/OTHER

21X Coronary Care

Routine service charge for medical care provided to patients with coronary illness who require a more intensive level of care than is rendered in the general medical care unit.

Rationale: If a discrete unit exists for rendering such services, the hospital or third party may wish to identify the service.

Subcategory	Standard Abbreviation
0 - General Classification	CORONARY CARE or (CCU)
1 - Myocardial Infarction	CCU/MYO INFARC
2 - Pulmonary Care	CCU/PULMONARY
3 - Heart Transplant	CCU/TRANSPLANT
4 - PRE/Post-CCU	PRE/POST CCU
9 - Other Coronary Care	CCU/OTHER

ANCILLARY REVENUE CODES (22X - 99X)

22X Special Charges

Charges incurred during an inpatient stay or on a daily basis for certain services.

Rationale: Some hospitals prefer to identify the components of services rendered in greater detail and thus break out charges for items that normally would be considered part of routine services.

Subcategory	Standard Abbreviation
0 - General Classification	SPECIAL CHARGES
1 - Admission Charge	ADMIT CHARGE
2 - Technical Support Charge	TECH SUPPT CHG
3 - U.R. Service Charge	UR CHARGE
4 - Late Discharge, medically necessary	LATE DISCH/MED NEC
9 - Other Special Charges	OTHER SPEC CHG

23X Incremental Nursing Charge Rate

Charge for nursing service assessed in addition to room and board.

Subcategory	Standard Abbreviation
0 - General Classification	NURSING INCREM
1 - Nursery	NUR INCR/NURSERY
2 - OB	NUR INCR/OB
3 - ICU (includes transitional care)	NUR INCR/ICU
4 - CCU (includes transitional care)	NUR INCR/CCU
5 - Hospice	NUR INCR/HOSPICE
9 - Other	NUR INCR/OTHER

24X All Inclusive Ancillary

A flat rate charge incurred on either a daily basis or total stay basis for ancillary services only.

Rationale: Hospitals that bill in this manner may wish to segregate these charges.

Subcategory	Standard Abbreviation
0 - General Classification	ALL INCL ANCIL
9 - Other Inclusive Ancillary	ALL INCL ANCIL/OTHER

25X **Pharmacy**

Charges for medication produced, manufactured, packaged, controlled, assayed, dispensed and distributed under the direction of licensed pharmacist.

Rationale: Additional breakdowns are provided for items that individual hospitals may wish to identify because of internal or third party payer requirements.

Subcategory	Standard Abbreviation
0 - General Classification	PHARMACY
1 - Generic Drugs	DRUGS/GENERIC
2 - Non-generic drugs	DRUGS/NONGENERIC
3 - Take Home Drugs	DRUGS/TAKEHOME
6 - Experimental Drugs	DRUGS/EXPERIMT
7 - Non-prescription	DRUGS/NONPSCRPT
8 - IV Solutions	IV SOLUTIONS
9 - Other Pharmacy	DRUGS/OTHER

26X **IV Therapy**

Administration of intravenous solution by specially trained personnel to individuals requiring such treatment. This code should be used only when a discrete service unit exists.

Subcategory	Standard Abbreviation
0 - General Classification	IV THERAPY
1 - Infusion Pump	IV THER/INFSN PUMP
9 - Other IV Therapy	IV THERAPY/OTHER

27X Medical/Surgical Supplies

Charges for supply items required for patient care.

Rationale: Additional breakdowns are provided for items that hospitals may wish to identify because of internal or third party payer requirements.

Subcategory	Standard Abbreviation
0 - General Classification	MED-SUR SUPPLIES
2 - Sterile Supply	STERILE SUPPLY
3 - Take Home Supplies	TAKEHOME SUPPLY
4 - Prosthetic Devices	PROSTHETIC DEV
5 - Pace maker	PACE MAKER
7 - Oxygen-Take Home	02/TAKEHOME
8 - Other Implants	SUPPLY/IMPLANTS
9 - Other Devices	SUPPLY/OTHER

28X Oncology

Charges for the treatment of tumors and related diseases.

Subcategory	Standard Abbreviation
0 - General Classification	ONCOLOGY
9 - Other Oncology	ONCOLOGY/OTHER

29X Durable Medical Equipment (Other Than Renal)

Charge for medical equipment that can withstand repeated use (excluding renal equipment).

Rationale: Medicare requires a separate revenue center for billing.

Subcategory	Standard Abbreviation
0 - General Classification	MED EQUIP/DURAB
1 - Rental	MED EQUIP/RENT
2 - Purchase of new DME	MED EQUIP/NEW
3 - Purchase of used DME	MED EQUIP/USED
9 - Other Equipment	MED EQUIP/OTHER

30X Laboratory

Charges for the performance of diagnostic and routine clinical laboratory tests.

Rationale: A breakdown of the major areas in the laboratory is provided in order to meet hospital needs or third party billing requirements.

Subcategory	Standard Abbreviation
0 - General Classification	LABORATORY or (LAB)
1 - Chemistry	LAB/CHEMISTRY
2 - Immunology	LAB/IMMUNOLOGY
3 - Renal Patient (Home)	LAB/RENAL HOME
4 - Non-Routine Dialysis	LAB/NR DIALYSIS
5 - Hematology	LAB/HEMOTOLOGY
6 - Bacteriology & Microbiology	LAB/BACT-MICRO
7 - Urology	LAB/UROLOGY
9 - Other Laboratory	LAB/OTHER

31X Laboratory Pathological

Charges for diagnostic and routine laboratory tests on tissues and culture.

Rationale: A breakdown of the major areas that hospitals may wish to identify is provided.

Subcategory	Standard Abbreviation
0 - General Classification	PATHOLOGY LAB or (PATH LAB)
1 - Cytology	PATHOL/CYTOLOGY
2 - Histology	PATHOL/HYSTOL
4 - Biopsy	PATHOL/BIOPSY
9 - Other	PATHOL/OTHER

32X Radiology - Diagnostic

Charges for diagnostic radiology services provided for the examination and care of patients. Includes: taking, processing, examining and interpreting radiographs and fluorographs.

Rationale: A breakdown is provided of the major areas and procedures that individual hospitals or third party payers may wish to identify.

Subcategory	Standard Abbreviation
0 - General Classification	DX X-RAY
1 - Angiocardiography	DX X-RAY/ANGIO
4 - Chest X-Ray	DX X-RAY/CHEST
9 - Other	DX X-RAY/OTHER

33X Radiology - Therapeutic

Charges for therapeutic radiology services and chemotherapy are required for care and treatment of patients. Includes therapy by injection or ingestion of radioactive substances.

Rationale: A breakdown is provided of the major areas that hospitals or third parties may wish to identify. Chemotherapy - IV was added at the request of Ohio.

Subcategory	Standard Abbreviation
0 - General Classification	RX X-RAY
1 - Chemotherapy - Injected	CHEMOTHER/INJ
2 - Chemotherapy - Oral	CHEMOTHER/ORAL
3 - Radiation Therapy	RADIATION RX
5 - Chemotherapy - IV	CHEMOTHERP-IV
9 - Other	RX X-RAY/OTHER

34X **Nuclear Medicine**

Charges for procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of patients.

Rationale: A breakdown is provided in case hospitals desire or are required to identify the type of service rendered.

Subcategory	Standard Abbreviation
0 - General Classification	NUCLEAR MEDICINE or (NUC MED)
1 - Diagnostic	NUC MED/DX
2 - Therapeutic	NUC MED/RX
9 - Other	NUC MED/OTHER

35X **CT Scan**

Charges for computed tomographic scans of the head and other parts of the body.

Rationale: Due to coverage limitations some third party payers require that the specific test be identified.

Subcategory	Standard Abbreviation
0 - General Classification	CT SCAN
1 - Head Scan	CT SCAN/HEAD
2 - Body Scan	CT SCAN/BODY
9 - Other CT Scans	CT SCAN/OTHER

36X **Operating Room Services**

Charges for services provided to patients by specially trained nursing personnel who provide assistance to physicians in the performance of surgical and related procedures during and immediately following surgery.

Rationale: Permits identification of particular services.

Subcategory	Standard Abbreviation
0 - General Classification	OR SERVICES
1 - Minor Surgery	OR/MINOR
2 - Organ Transplant-other than kidney	OR/ORGAN TRANS
7 - Kidney Transplant	OR/KIDNEY TRANS
9 - Other Operating Room Services	OR/OTHER

37X Anesthesia

Charges for anesthesia services in the hospital.

Rationale: Provides additional identification of services. In particular, acupuncture was identified because it is not covered by some payers, including Medicare.

Subcategory	Standard Abbreviation
0 - General Classification	ANESTHESIA
4 - Acupuncture	ANESTHE/ACUPUNC
9 - Other Anesthesia	ANESTHE/OTHER

38X Blood

Rationale: Charges for blood must be separately identified for private payer purposes.

Subcategory	Standard Abbreviation
0 - General Classification	BLOOD
1 - Packed Red Cells	BLOOD/PKD RED
2 - Whole Blood	BLOOD/WHOLE
3 - Plasma	BLOOD/PLASMA
4 - Platelets	BLOOD/PLATELETS
5 - Leucocytes	BLOOD/LEUCOCYTES
6 - Other Components	BLOOD/COMPONENTS
7 - Other Derivatives (Cryopricipatates)	BLOOD/DERIVATIVES
9 - Other Blood	BLOOD/OTHER

39X Blood Storage and Processing

Charges for the storage and processing of whole blood.

Subcategory	Standard Abbreviation
0 - General Classification	BLOOD/STOR-PROC
1 - Blood Administration	BLOOD/ADMIN.
9 - Other Blood Storage & Processing	BLOOD/OTHER STOR

40X Other Imaging Services

Subcategory	Standard Abbreviation
0 - General Classification	IMAGE SERVICE
1 - Mammography	MAMMOGRAPHY
2 - Ultrasound	ULTRASOUND
3 - Magnetic Resonance Imaging	MRI
9 - Other Imaging Services	OTHER IMAG SVS

41X Respiratory Services

Charges for administration of oxygen and certain potent drugs through inhalation or positive pressure and other forms of rehabilitative therapy through measurement of inhaled and exhaled gases and analysis of blood and evaluation of the patient's ability to exchange oxygen and other gases.

Rationale: Permits identification of particular services.

Subcategory	Standard Abbreviation
0 - General Classification	RESPIRATORY SVC
2 - Inhalation Services	INHALATION SVC
3 - Hyperbaric Oxygen Therapy	HYPERBARIC 02
9 - Other Respiratory Services	OTHER RESPIR SVS

42X Physical Therapy

Charges for therapeutic exercises, massage and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic and other disabilities.

Rationale: Permits identification of particular services.

Subcategory	Standard Abbreviation
0 - General Classification	PHYSICAL THERP
1 - Visit Charge	PHYS THERP/VISIT
2 - Hourly Charge	PHYS THERP/HOUR
3 - Group Rate	PHYS THERP/GROUP
4 - Evaluation or Re-evaluation	PHYS THERP/EVAL
9 - Other Physical Therapy	OTHER PHYS THERP

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43X Occupational Therapy

Charges for teaching manual skills and independence in personal care to stimulate mental and emotional activity on the part of patients.

Subcategory	Standard Abbreviation
0 - General Classification	OCCUPATION THER
1 - Visit Charge	OCCUP THERP/VISIT
2 - Hourly Charge	OCCUP THERP/HOUR
3 - Group Rate	OCCUP THERP/GROUP
4 - Evaluation or Re-evaluation	OCCUP THERP/EVAL
9 - Other Occupational Therapy (may include restorative therapy)	OTHER OCCUP THER

44X Speech-Language Pathology

Charges for services provided to persons with impaired functional communications skills.

Subcategory	Standard Abbreviation
0 - General Classification	SPEECH PATHOL
1 - Visit Charge	SPEECH PATH/VISIT
2 - Hourly Charge	SPEECH PATH/HOUR
3 - Group Rate	SPEECH PATH/GROUP
4 - Evaluation or Re-evaluation	SPEECH PATH/EVAL
9 - Other Speech-Language Pathology	OTHER SPEECH PAT

45X Emergency Room

Charges for emergency treatment to those ill and injured persons who require immediate unscheduled medical or surgical care.

Rationale: Permits identification of particular items for payers

Subcategory	Standard Abbreviation
0 - General Classification	EMERG ROOM
9 - Other Emergency Room	OTHER EMER ROOM

46X Pulmonary Function

Charges for tests that measure inhaled and exhaled gases and analysis of blood and for tests that evaluate the patient's ability to exchange oxygen and other gases.

Rationale: Permits identification of this service if it exists in the hospital.

Subcategory	Standard Abbreviation
0 - General Classification	PULMONARY FUNC
9 - Other Pulmonary Function	OTHER PULMON FUNC

47X Audiology

Charges for the detection and management of communication handicaps centering in whole or in part on the hearing function.

Rationale: Permits identification of particular services.

Subcategory	Standard Abbreviation
0 - General Classification	AUDIOLOGY
1 - Diagnostic	AUDIOLOGY/DX
2 - Treatment	AUDIOLOGY/RX
9 - Other Audiology	OTHER AUDIOL

48X Cardiology

Charges for cardiac procedures rendered in a separate unit within the hospital. Such procedures include, but are not limited to: heart catheterization, coronary angiography, Swan-Ganz catheterization, and exercise stress test.

Rationale: This category was established to reflect a growing trend to incorporate these charges in a separate unit.

Subcategory	Standard Abbreviation
0 - General Classification	CARDIOLOGY
1 - Cardiac Cath Lab	CARDIAC CATH LAB
2 - Stress Test	STRESS TEST
9 - Other Cardiology	OTHER CARDIOL

49X Ambulatory Surgical Care

Charges for ambulatory surgery which are not covered by any other category.

Subcategory	Standard Abbreviation
0 - General Classification	AMBUL SURG
9 - Other Ambulatory Surgical Care	OTHER AMBL SURG

50X Outpatient Services

Outpatient charges (other than those for scheduled Preadmission Testing) for services rendered to an outpatient who is admitted as an inpatient before midnight of the day following the date of services. These charges are incorporated on the inpatient bill of Medicare patients.

51X Clinic

Clinic (non-emergency/scheduled outpatient visit) charges for providing diagnostic, preventive, curative, rehabilitative, and education services on a scheduled basis to ambulatory patients.

Rationale: Provides a breakdown of some clinics that hospitals or third party payers may require.

Subcategory	Standard Abbreviation
0 - General Classification	CLINIC
1 - Chronic Pain Center	CHRONIC PAIN CL
2 - Dental Clinic	DENTAL CLINIC
9 - Other Clinic	OTHER CLINIC

52X Free-Standing Clinic

Rationale: Provides a breakdown of some clinics that hospitals or third party payers may require.

Subcategory	Standard Abbreviation
0 - General Classification	FREESTAND CLINIC
1 - Rural Health-Clinic	RURAL/CLINIC
2 - Rural Health-Home	RURAL/HOME
3 - Family Practice	FAMILY PRACTICE
9 - Other Freestanding Clinic	OTHER FR/STD CLINIC

53X Osteopathic Services

Charges for a structural evaluation of the cranium, entire cervical, dorsal and lumbar spine by a doctor of osteopathy.

Rationale: There is a service unique to osteopathic hospitals and cannot be accommodated in any of the existing codes.

Subcategory	Standard Abbreviations
0 - General Classification	OSTEOPATH SVS
1 - Osteopathic Therapy	OSTEOPATH RX
9 - Other Osteopathic Services	OTHER OSTEOPATH

54X Ambulance

Charges for ambulance service, usually on an unscheduled basis to the ill and injured who require immediate medical attention.

Rationale: Provides subcategories that third party payers or hospitals may wish to recognize. Heart mobile is a specially designed ambulance transport for cardiac patients.

Subcategory	Standard Abbreviation
0 - General Classification	AMBULANCE
1 - Supplies	AMBUL/SUPPLY
2 - Medical Transport	AMBUL/MED TRANS
3 - Heart Mobile	AMBUL/HEARTMOBL
4 - Oxygen	AMBUL/0XY
5 - Air Ambulance	AIR AMBULANCE
6 - Neo-natal ambulance	AMBUL/NEO-NATAL
9 - Other Ambulance	OTHER AMBULANCE

55X Skilled Nursing

Charges for nursing services that must be provided under the direct supervision of a licensed nurse to assure the safety of the patient and to achieve the medically desired result. This code may be used for nursing home services or a service charge for home health billing.

Subcategory	Standard Abbreviation
0 - General Classification	SKILLED NURSING
1 - Visit Charge	SKILLED NURS/VISIT
2 - Hourly Charge	SKILLED NURS/HOUR
9 - Other Skilled Nursing	SKILLED NURS/OTHER

56X Medical Social Services

Charges for services such as counseling patients, interviewing patients, and interpreting problems of social situation rendered to patients on any basis.

Rationale: Necessary for Medicare home health billing requirements. May be used at other times as required by hospital.

Subcategory	Standard Abbreviation
0 - General Classification	MED SOCIAL SVS
1 - Visit Charge	MED SOC SERV/VISIT
2 - Hourly Charge	MED SOC SERV/HOUR
9 - Other Med. Soc. Services	MED SOC SERV/OTHER

57X Home Health Aide (Home Health)

Charges made by a home health agency for personnel that are primarily responsible for the personal care of the patient.

Rationale: Necessary for Medicare home health billing requirements.

Subcategory	Standard Abbreviation
0 - General Classification	AIDE/HOME HEALTH
1 - Visit Charge	AIDE/HOME HLTH/VISIT
2 - Hourly Charge	AIDE/HOME HLTH/HOUR
9 - Other Home Health Aide	AIDE/HOME HLTH/OTHER

58X Other Visits (Home Health)

Charges by a home health agency for visits other than physical therapy, occupational therapy or speech therapy, which must be specifically identified.

Rationale: Necessary for Medicare home health billing requirements.

Subcategory	Standard Abbreviation
0 - General Classification	VISIT/HOME HEALTH
1 - Visit Charge	VISIT/HOME HLTH/VISIT
2 - Hourly Charge	VISIT/HOME HLTH/HOUR
9 - Other Home Health Visits	VISIT/HOME HLTH/OTHER

59X Units of Service (Home Health)

Revenue code used by a home health agency that bills on the basis of units of service.

Rationale: Necessary for Medicare home health billing requirements.

Subcategory	Standard Abbreviation
0 - General Classification	UNIT/HOME HEALTH
9 - Home Health Other Units	UNIT/HOME HLTH/OTHER

60X Not Assigned (May be reserved for other Clinics)

61X Not Assigned

62X Not Assigned

63X Not Assigned

64X Not Assigned

65X Hospice Services

Charges for hospice care services for a terminally ill patient if he elects these services in lieu of other services for the terminal condition.

Rationale: The level of hospice care provided for each day during a hospice election period determines the amount of Medicare payment for that day.

Subcategory	Standard Abbreviation
0 - General Classification	HOSPICE
1 - Routine Home Care	HOSPICE/RTN HOME
2 - Continuous Home Care - 1/2	HOSPICE/CTNS HOME
5 - Inpatient Care	HOSPICE/IP RESPITE
6 - General Inpatient Care (Non-Respite)	HOSPICE/IP NON RESPITE
7 - Physician Services	HOSPICE/PHYS SVC
9 - Other Hospice	HOSPICE/OTHER

66X Not Assigned

67X Not Assigned

68X Not Assigned

69X Not Assigned

70X Cast Room

Charges for services related to the application, maintenance and removal of casts.

Rationale: Permits identification of this service if necessary.

Subcategory	Standard Abbreviation
0 - General Classification	CAST ROOM
9 - Other Cast Room	OTHER CAST ROOM

71X Recovery Room

Rationale: Permits identification of particular services if necessary.

Subcategory	Standard Abbreviation
0 - General Classification	RECOVERY ROOM
9 - Other Recovery Room	OTHER RECOV RM

72X Labor Room/Delivery

Charges for labor and delivery room services provided by specially trained nursing personnel to patients, including prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecologic procedures if they are performed in the delivery suite.

Rationale: Provides a breakdown of items that may require further clarification. Infant circumcision is included because it is not covered by all third party payers.

Subcategory	Standard Abbreviation
0 - General Classification	DELIVROOM/LABOR
1 - Labor	LABOR
2 - Delivery	DELIVERY ROOM
3 - Circumcision	CIRCUMCISION
4 - Birthing Center	BIRTHING CENTER
9 - Other Labor Room/Delivery	OTHER/DELIV-LABOR

73X EKG/ECG (Electrocardiogram)

Charges for operation of specialized equipment to record electromotive variations in actions of the heart muscle on an electrocardiograph for diagnosis of heart ailments.

Subcategory	Standard Abbreviation
0 - General Classification	EKG/ECG
1 - Holter Monitor	HOLTER MONT
2 - Telemetry (includes fetal monitoring)	TELEMETRY
9 - Other EKG/ECG	OTHER EKG-ECG

74X EEG (Electroencephalogram)

Charges for operation of specialized equipment to measure impulse frequencies and differences in electrical potential in various areas of the brain to obtain data for use in diagnosing brain disorders.

Subcategory	Standard Abbreviation
0 - General Classification	EEG
9 - Other EEG	OTHER EEG

75X Gastro-Intestinal Services

Procedure room charges for endoscopic procedures not performed in an operating room.

Subcategory	Standard Abbreviation
0 - General Classification	GASTR-INTS SVS
9 - Other Gastro-Intestinal	OTHER GASTRO-INTS

76X Not Assigned

77X Not Assigned

78X Not Assigned

79X Not Assigned

80X Inpatient Renal Dialysis

A waste removal process, performed in an inpatient setting, that uses an artificial kidney when the body's own kidneys have failed. The waste may be removed directly from the blood (hemodialysis) or indirectly from the blood by flushing a special solution between the abdominal covering and the tissue (peritoneal dialysis).

Rationale: Specific identification required for billing purposes.

Subcategory	Standard Abbreviation
0-General Classification	RENAL DIALYSIS
1-Inpatient Hemodialysis	DIALY/INPT
2-Inpatient Peritoneal (Non-CAPD)	DIALY/INPT/PER
3-Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)	DIALY/INPT/CAPD
4-Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)	DIALY/INPT/CCPD
9-Other Inpatient Dialysis	DIALY/INPT/OTHER

81X Kidney Acquisition

The acquisition of a kidney for use in transplantation.

Rationale: Living donor is a living person from whom a kidney is obtained for transplantation. Cadaver is an individual who has been pronounced dead according to medical and legal criteria, from whom a kidney is obtained for transplantation.

Medicare requires detailed revenue coding; therefore, codes for this series may not be summed at the zero level.

Subcategory	Standard Abbreviation
0-General Classification	KIDNEY ACQUISIT
1-Living Donor	KIDNEY/LIVE
2-Cadaver Donor	KIDNEY/CADAVER
3-Unknown Donor	KIDNEY/UNKNOWN

82X Hemodialysis - Outpatient or Home Dialysis

A waste removal process, performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood.

Rationale: Detailed revenue coding is required; therefore, services may not be summed at the zero level.

Subcategory	Standard Abbreviation
0-General Classification	HEMO/OP OR HOME
1-Hemodialysis/Composite or other rate	HEMO/OP/COMPOSITE
2-Home Supplies	HEMO/HOME/SUPPL
3-Home Equipment	HEMO/HOME/EQUIP
4-Maintenance/100%	HEMO/HOME/100%
5-Support Services	HEMO/HOME/SUPSERV
9-Other Hemodialysis Outpatient	HEMO/HOME/OTHER

83X Peritoneal dialysis - Outpatient or Home

A waste removal process, performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by flushing a special solution between the abdominal covering and the tissue.

Subcategory	Standard Abbreviation
0-General Classification	PERITONEAL/OP OR HOME
1-Peritoneal/Composite or other rate	PERTNL/OP/COMPOSITE
2-Home Supplies	PERTNL/HOME/SUPPL
3-Home Equipment	PERTNL/HOME/EQUIP
4-Maintenance/100%	PERTNL/HOME/100%
5-Support Services	PERTNL/HOME/SUPSERV
9-Other Peritoneal Dialysis	PERTNL/HOME/OTHER

X **Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient**

A continuous dialysis process, performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

Subcategory	Standard Abbreviation
0-General Classification	CAPD/OP OR HOME
1-CAPD/Composite or other rate	CAPD/OP/COMPOSITE
2-Home Supplies	CAPD/HOME/SUPPL
3-Home Equipment	CAPD/HOME/EQUIP
4-Maintenance/100%	CAPD/HOME/100%
5-Support Services	CAPD/HOME/SUPSERV
9-Other CAPD Dialysis	CAPD/HOME/OTHER

5X **Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient**

A continuous dialysis process, performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

Subcategory	Standard Abbreviation
0-General Classification	CCPD/OP OR HOME
1-CCPD/Composite or other rate	CCPD/OP/COMPOSITE
2-Home Supplies	CCPD/HOME/SUPPL
3-Home Equipment	CCPD/HOME/EQUIP
4-Maintenance/100%	CCPD/HOME/100%
5-Support Services	CCPD/HOME/SUPSERV
9-Other CCPD Dialysis	CCPD/HOME/OTHER

3X **Reserved for Dialysis (National Assignment**

7X **Reserved for Dialysis (State Assignment**

88X Miscellaneous Dialysis

Charges for dialysis services not identified elsewhere.

Rationale: Ultrafiltration is the process of removing excess fluid from the blood of dialysis patients by using a dialysis machine but without the dialysate solution. The designation is only used when the procedure is not performed as part of a normal dialysis session.

Subcategory	Standard Abbreviations
0 - General Classification	DIALY/MISC
1 - Ultrafiltration	DIALY/ULTRAFILT
9 - Misc. Dialysis Other	DIALY/MISC/OTHER

89X Other Donor Bank

Charges for the acquisition, storage and preservation of all human organs (excluding kidneys).

Rationale: Provides a breakdown identifying the specific organ category.

Subcategory	Standard Abbreviation
0 - General Classification	DONOR BANK
1 - Bone	DONOR BANK/BONE
2 - Organ (other than kidney)	DONOR BANK/ORGN
3 - Skin	DONOR BANK/SKIN
9 - Other Donor Bank	OTHER DONOR BANK

90X Psychiatric/Psychological Treatments

Subcategory	Standard Abbreviation
0 - General Classification	PSTAY TREATMENT
1 - Electroshock Treatment	ELECTRO SHOCK
2 - Milieu Therapy	MILIEU THERAPY
3 - Play Therapy	PLAY THERAPY
9 - Other	OTHER PSTAY RX

91X Psychiatric/Psychological Services

Charges for providing nursing care and employee, professional services for emotionally disturbed patients, including patients admitted for diagnosis and those admitted for treatment.

Rationale: Provides additional identification of services as necessary.

Subcategory	Standard Abbreviation
0 - General Classification	PSTAY SERVICES
1 - Rehabilitation	PSTAY/REHAB
2 - Day Care	PSTAY/DAYCARE
3 - Night Care	PSTAY/NIGHTCARE
4 - Individual Therapy	PSTAY/INDIV RX
5 - Group Therapy	PSTAY/GROUP RX
6 - Family Therapy	PSTAY/FAMILY RX
7 - Bio Feedback	PSTAY/BIOFEED
8 - Testing	PSTAY/TESTING
9 - Other	PSTAY/OTHER

92X Other Diagnostic Services

Charges for other diagnostic services not otherwise categorized.

Subcategory	Standard Abbreviations
0 - General Classification	OTHER DX SVS
1 - Peripheral Vascular Lab	PERI VASCUL LAB
2 - Electromyelogram	EMG
3 - Pap Smear	PAP SMEAR
4 - Allergy test	ALLERGY TEST
5 - Pregnancy test	PREG TEST
9 - Other Diagnostic Service	ADDITIONAL DX SVS

93X Not Assigned

94X Other Therapeutic Services

Charges for other therapeutic services not otherwise categorized.

Subcategory	Standard Abbreviations
0 - General Classification	OTHER RX SVS
1 - Recreational Therapy	RECREATION RX
2 - Education/Training (includes diabetes related dietary therapy)	EDUC/TRAINING
3 - Cardiac Rehabilitation	CARDIAC REHAB
4 - Drug Rehabilitation	DRUG REHAB
5 - Alcohol Rehabilitation	ALCOHOL REHAB
9 - Other Therapeutic Services	ADDITIONAL RX SVS

95X Not Assigned

96X Professional Fees

Charges for medical professionals that the hospitals or third party payers require to be separately identified on the billing form. Services that were not identified separately prior to uniform billing implementation should not be separately identified on the uniform bill.

Subcategory	Standard Abbreviations
0 - General Classification	PRO FEE
1 - Psychiatric	PRO FEE/PSTAY
2 - Opthalmology	PRO FEE/EYE
3 - Anesthesiologist (MD)	PRO FEE/ANES MD
4 - Anesthetist (RN)	PRO FEE/ANES RN
9 - Other Professional Fees	OTHER PRO FEE

97X Professionals Fees (cont.)

Subcategory	Standard Abbreviations
1 - Laboratory	PRO FEE/LAB
2 - Radiology - Diagnostic	PRO FEE/RAD/DX
3 - Radiology - Therapeutic	PRO FEE/RAD/RX
4 - Radiology - Nuclear Medicine	PRO FEE/NUC MED
5 - Operating Room	PRO FEE/OR
6 - Respiratory Therapy	PRO FEE/RESPIR
7 - Physical Therapy	PRO FEE/PHYSI
8 - Occupational Therapy	PRO FEE/OCUPA
9 - Speech Pathology	PRO FEE/SPEECH

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98X **Professional Fees (cont.)**

Subcategory	Standard Abbreviations
1 - Emergency Room	PRO FEE/ER
2 - Outpatient Services	PRO FEE/OUTPT
3 - Clinic	PRO FEE/CLINIC
4 - Medical Social Services	PRO FEE/SOC SVC
5 - EKG	PRO FEE/EKG
6 - EEG	PRO FEE/EEG
7 - Hospital Visit	PRO FEE/HOS VIS
8 - Consultation	PRO FEE/CONSULT
9 - Private Duty Nurse	FEE/PVT NURSE

99X **Patient Convenience Items**

Charges for items that are generally considered by the third party payers to be strictly convenience items and, as such, are not covered.

Rationale: Permits identification of particular services as necessary.

Subcategory	Standard Abbreviation
0 - General Classification	PT CONVENIENCE
1 - Cafeteria/Guest Tray	CAFETERIA
2 - Private Linen Service	LINEN
3 - Telephone/Telegraph	TELEPHONE
4 - TV/Radio	TV/RADIO
5 - Nonpatient Room Rentals	NONPT ROOM RENT
6 - Late Discharge Charge	LATE DISCHARGE
7 - Admission Kits	ADMIT KITS
8 - Beauty Shop/Barber	BARBER/BEAUTY
9 - Other Patient Convenience Items	PT CONVENCE/OTH

Data Element: **Source of admission**

Definition: **A code indicating the source of this admission.**

Code:

1 - Physician Referral	**The patient was admitted to this facility upon the recommendation of his or her personal physician.**
2 - Clinic Referral	**The patient was admitted to this facility upon the recommendation of this facility's clinic physician.**
3 - HMO Referral	**The patient was admitted to this facility upon the recommendation of a health maintenance organization physician.**
4 - Transfer from a Hospital	**The patient was admitted to this facility as a transfer from an acute care facility where he or she was an inpatient.**
5 - Transfer from a Skilled Nursing Facility	**The patient was admitted to this facility as a transfer from a skilled nursing facility where he or she was an inpatient.**
6 - Transfer from Another Health Care Facility	**The patient was admitted to this facility as a transfer from a health care facility other than an acute care facility or a skilled nursing facility.**
7 - Emergency Room	**The patient was admitted to this facility upon the recommendation of this facility's emergency room physician.**
8 - Court/Law Enforcement	**The patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative.**
9 - Information Not Available	The means by which the patient was admitted to this hospital is not known.

Code Structure (Newborn):

1 - Normal Delivery	A baby delivered without complications.
2 - Premature Delivery	A baby delivered with time and/or weight factors qualifying it for premature status.
3 - Sick baby	A baby delivered with medical complications, other than those relating to premature status.
4 - Extra Mural Birth	A newborn born in a non-sterile environment.
5 -8	Reserved for national assignment
9 -	Information Not Available

Data Element: Source of Payment

Definition: A code indicating source of payment associated with this payer record.

A - Self pay
B - Workers Compensation
C - Medicare
D - Medicaid
E - Other Federal Programs
F - Insurance company
G - Blue Cross
H - CHAMPUS
I - Other - local coding table applies

Data Element: **Special Program Indicator**

Definition: **A code indicating that the services included on this bill are related to a special program.**

Code Structure

01	EPSDT/CHAP	**Early and Periodic Screening, Diagnosis and Treatment.**
02	Physically Handicapped Children's Program	**Services provided under this program receive special funding through Title 8 of the Social Security Act or the CHAMPUS Program for the Handicapped.**
03	Special Federal Funding	**This code has been designed for uniform use by state uniform billing committees.**
04	Family Planning	**This code has been designed for uniform use by state uniform billing committees.**
05	Disability	**This code has been designed for uniform use by state uniform billing committees.**
06	PPV/Medicare 100% payment	**This code identifies that pneumococcal pneumonia vaccine (PPV) services given should be reimbursed under a special Medicare program provision.**
07	Induced abortion - danger to life	Abortion was performed to avoid danger to woman's life.
08	Induced abortion Victim rape/incest	Self explanatory.
09-79		Reserved for National Assignment.
80-99		Reserved for State Assignment.

Data Element: Type of Admission

Definition: A Code indicating the priority of this admission.

1 = Emergency	The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room.
2 = Urgent	The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally the patient is admitted to the first available and suitable accommodation.
3 = Elective	The patient's condition permits adequate time to schedule the availability of a suitable accommodation.
4 = Newborn	Necessitates the use of special Source of Admission codes.
5-8	Reserved for National Assignment
9	Information Not Available

Data Element:	Type of batch
Definition:	A code indicating the type of bill that occurs in this batch; i.e., between a provider record (record type 10) and a batch control (record type 95). The "Type of Batch" code is exactly the same as the "Type of Bill" code shown on the following page.

Data Element: Type of Bill

Definition: A code indicating the specific type of bill (inpatient, outpatient, adjustments, voids, etc.)

Code Structure

Type of Facility - 1st Digit

Hospital	1
Skilled Nursing	2
Home Health	3
Christian Science (Hospital)	4
Christian Science (Extended Care)	5
Intermediate Care	6
Clinic	7
Special Facility	8
Reserved for National Use	9

Bill Classification (Except Clinics and Special Facilities) - 2nd Digit

Inpatient (Including Part A)	1
Inpatient (Part B only)	2
Outpatient	3
Other (for Medicare Part B use only)	4
Intermediate Care - Level I	5
Intermediate Care - Level II	6
Intermediate Care - Level III	7
Swing Beds	8
Reserved for National Assignment	9

Bill Classification (Clinics) 2nd digit		Bill Classification - Special Facilities - 2nd digit
Rural Health	1	Hospice (non-hospital based)
Free Standing Renal Dialysis Center	2	Hospice (hospital based)
Free Standing	3	Ambulatory Surgical Center
CORF	4	Free Standing Birthing Center
Reserved for National Use	5-8	Reserved for National Use
Other	9	Other

Frequency - 3rd Digit

Non-Payment/Zero claim	0
Admit thru Discharge Claim	1
Interim - First claim	2
Interim - Continuing claim	3
Interim - Last claim	4
Late Charge(s) Only Claim	5
Adjustment of prior claim	6
Replacement of prior claim	7
Void/cancel of prior claim	8
Reserve for National Assignment	9

Data Element: Value Code

Data Definition: A code that identifies data of a monetary nature that is necessary for processing this claim as qualified by the payer organization.

Code Structure

01	Most Common Semi-Private Rate	To provide for the recording of hospital's most common semi-private rate.
02	Hospital has no Semi-Private Rooms	Entering this code requires $0.00 amount.
05	Professional Component included in Charges and also billed separate to Carrier.	For use on Medicare bills and Medicaid bills if State specifies the need for this information.
06	Medicare Blood Deductible	Total cash blood deductible, if appropriate.
07	Medicare Cash Deductible	Medicare cash deductible to be used only if 06 is used and there is a cash deductible.
08	Medicare Life Time Reserve Amount in the first calendar year.	Medicare life time reserve amount charged in the year of admission.
09	Medicare Coinsurance Amount in the First Calendar Year.	Medicare co-insurance amount charged in the year of admission.
10	Medicare Life Time Reserve Amount in the second calendar year.	Medicare life time reserve amount charged in the year of discharge where the bil spans two calendar years.
11	Medicare Coinsurance Amount in the second Calendar Year.	Medicare co-insurance amount charged in the year of discharge where the bil spans two calendar years.
12	Working Aged Beneficiary/ Spouse with Employer Group Health Plan	Amount shown is that portion of a payment from a higher priority employer group health insurance made on behalf of an aged beneficiary that the provider is applying to Medicare covered services on this bill. If six zeroes are entered, the provider is claiming conditional Medicare payment.

12	ESRD Beneficiary in the 12 month coordination period with Employer Group Health Plan	Amount shown is that portion of a payment from a higher priority employer group health insurance made on behalf of an ESRD beneficiary that the provider is applying to Medicare covered services on this bill. If six zeroes are entered, the provider is claiming conditional Medicare payment.
14	Automobile, No Fault or any Liability Insurance	Amount shown is that portion of a payment from a higher priority automobile, no fault or liability insurance made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered Services on this bill. If six zeroes are entered, the provider is claiming conditional Medicare payment.
15	Worker's Compensation, including Black Lung	Amount shown is that portion of a payment from a higher priority Worker's Compensation insurance made in behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill. If six zeroes are entered, the provider is claiming conditional Medicare payment.
16	VA, PHS, or other including Black Lung	Amount shown is that portion of a payment from a higher priority Veteran's Administration, Public Health Service, or other Federal Agency made in behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill.
17	Payer Code	PROVIDERS DO NOT REPORT THIS. FOR PAYER INTERNAL USE ONLY. Indicates the amount of day or cost outlier payment to be made.
18-20		Reserved for National Assignment.

MEDICAID SPECIFIC CODES

21	Catastrophic	Medicaid-eligibility requirements to be determined at State level.
22	Surplus	Medicaid-eligibility requirements to be determined at State level.
23	Recurring Monthly Income	Medicaid-eligibility requirements to be determined at State level.
24	Medicaid Rate Code	Medicaid-eligibility requirements to be determined at state level.
25-29		Reserved for National Assignment - Medicaid.
30	Preadmission Testing	Reflects charges for preadmission outpatient diagnostic services for a patient in preparation for a previously scheduled admission.
31-79		Reserved for National Assignment.
80-99		Reserved for State and Local Assignment.

Home Health Data Elements-Cross Reference
HCFA-485 Home Health Certification and Plan of Treatment

Form Item	Form Description	Location in Electronic Record	Comments
1	Patient's Name and Address	Record Type (RT) 20 Fields 4-6 and 13-17	
2	Patient's HI Claim Number	RT 30, Field 7	
3	Medical Record Number	RT 20, Field 25	May or may not be the same as the Patient Control Number in Field 3 of each Record Type.
4	Dates: Start of Care and Verbal Order for SOC	RT 71, Field 6	Start of Care (SOC) Date only. Zeros if SOC Date is present in RT 20, Field 18.
5	Certification Period	RT 71, Field 4	
6	HHA Name and Address	RT 10, Fields 13-17	
7	Principal Diagnosis ICD-9-CM Code Date Onset/Excerbation	 RT 70, Field 4 RT 71, Field 7	ICD-9-CM code only and most recent date (i.e. date of onset or date of exacerbation).
8	Surgical Procedure ICD-9-CM Code Date of Procedure	RT 71, Fields 8-9	ICD-9-CM procedural code only and date for one procedure most relevant to the care being provided.
9	Other Pertinent Diagnoses ICD-9-CM Codes Dates of Onset/Exacerbation	RT 70, Fields 5-8 RT 71, Fields 10-13	ICD-9-CM diagnostic codes and most recent dates (i.e. onsets or exacerbation).
10	Functional Limitations Activities Permitted	RT 71, Fields 14-19	Up to 3 codes in each category which most support home bound status or care being provided.
11	Safety Measures	Not present	
12	Orders for Services and Treatment	RT 73	

Home Health Data Elements-Cross Reference
HCFA-485 Home Health Certification and Plan of Treatment (Cont)

Form Item	Form Description	Location in Electronic Record	Comments
13	Medications	RT 71, Fields 20-28	Up to 6 medications most pertinent to care being rendered.
14	Mental Status	RT 71, Fields 29-30	Up to 2 most relevant codes.
15	Nutritional Requirements	Not present	
16	Medical Supplies and DME ordered	RT 61	HCPCS codes.
17	Allergies	Not present	
18	Goals/Rehabilitation Potential/Discharge Plans	RT 73	
19	Significant Clinical Findings	RT 73	
20	Prognosis	RT 71, Field 31	
21	Attending Physician's Name and Address	RT 80	Name only.
22	Physician Certification	Not Present	The physician's certification signature and date must be present on the hard copy form retained in your file.
23	Attending Physician's Signature and Date	Not Present	

Home Health Data Elements-Cross Reference
HCFA-486 Medical Update and Patient Information

Form Item	Form Description	Location in Electronic Record	Comments
1	Patient's Name	RT 20, Field 4-6	
2	HIC No.	RT 30, Field 7	
3	Sex	RT 20, Field 7	
4	Date of Birth	RT 20, Field 8	
5	Medicare Covered	Not Present	
6	Period Covered	RT 71, Field 4	Field is not present if 486 data is requested separately on an interim bill.
7	Provider Name and No.	RT 10, Fields 6 and 13	
8	Place of Treatment	RT 72, Field 4	Indicates only if place of service is or is not a Nursing Home.
		RT 74, Fields 5-9	Name and address of Nursing Home if applicable.
9	Are Services Related to Any Accident or Employment Related Injury	RT 40	Present as a value code.
10	Date and Reason Agency Last Contacted Physician	Not Present	May be described in RT 73 "Clinical Findings" if contact was nonroutine. Otherwise will not be present.
11	Is Patient Receiving Additional Medically Reasonable and Necessary Skilled Care or Aide Services	RT 72, Field 5	Yes or no response.
		RT 74, Fields 10-15	If yes, description of service and other payor.
12	Dates of Last Inpatient Stay-Type of Facility	RT 72, Fields 6-8	
13	Date Physician Last Saw Patient	RT 72, Field 9	
14	Specific Services and Treatment	RT 72, Fields 10-26	
15	Updated Information	RT 73	

Home Health Data Elements-Cross Reference
HCFA-486 Medical Update and Patient Information (Cont)

Form Item	Form Description	Location in Electronic Record	Comments
16	Functional Limitations/ Rehabilitation Potential/Goals	RT 73	
17	Homebound		
	A. Reason Homebound	RT 73	
	B. Indicate times when the Home Health Agency made visit(s) and the patient was not at home and reasons	RT 72, Field 27	Field contains number of times only. If a medical problem, describe in clinical findings.
	C. Specify known medical and/or non-medical reasons patient regularly leaves home and frequency	RT 72, Fields 28-29	Reason is defined only as medical or non-medical.
18	Is there an available, able and willing caregiver	RT 72, Field 30	Yes or no response.
		RT 74, Field 16	Description if yes response.
19	Unusual Home/Social Environment	Not present	May be described in RT 73.
20	Supplementary Plans of treatment on file	RT 72, Field 31	Yes or no response.
		RT 74, Field 17	Description if yes response.
21	Other DME available	Not present	
22	Signature and Date	Not present	Must be on hard copy form retained in your files.

Record Type 71-Home Health Certification and Plan of Treatment-Data Definitions and Codes

Data Element	Definition	Field	Cross Reference HCFA-485
Certification Period	From/thru dates of period to be covered by this Plan of Treatment	4-5	5
Start of Care Date	Date home health services began	6	4
Date of Onset/Exacerbation of Principal Diagnosis	The date of onset or date of exacerbation of the diagnosis shown as principal in Record Type 70	7	7
Surgical Procedure Code	The ICD-9-CM code describing the surgical procedure (if any) most relevant to the care being rendered	8	8
Date of Surgical Procedure	The date the surgical procedure (Field 8) was performed	9	8
Dates of Onset/Exacerbation of Secondary Diagnoses	The date of onset or exacerbation of the secondary diagnoses shown in Record Type 70	10-13	9
Functional Limitations	1 to 3 codes describing the patient's functional limitations as assessed by the physician. If more than 3 codes are applicable, give the 3 most relevant to the care being rendered or most pertinent to the homebound status. 'Other' should be indicated in Record Type 73. 1 = Amputation 2 = Bowel/Bladder incontinence 3 = Contracture 4 = Hearing 5 = Paralysis	14-16	10

Record Type 71 - Home Health Certification and Plan of Treatment - Data Definitions and Codes

Data Element	Definition	Field	Cross Reference HCFA-485
	6 = Endurance 7 = Ambulation 8 = Mental 9 = Speech A = Vision B = Respiratory C = Other		
Activities Permitted	1 to 3 codes describing the activities permitted by the physician or for which physician's orders are present. 'Other' should be indicated in Record Type 73. 1 = Bedrest 2 = Up as Tolerated 3 = Transfer Bed/Chair 4 = Exercises Prescribed 5 = Partial Weight Bearing 6 = Independent at Home 7 = Crutches 8 = Cane 9 = Wheelchair A = Walker B = No Restrictions C = Other	17-19	10
Medications	Shows the six medications most relevant to the patient's care. Codes are defined in Addendum D pages 16 to 20.	20-28	13
Drug/Mode	Where HCPCS codes exist, the 5 position HCPCS code for the drug is entered. Where HCPCS do not exist, a 3 position code describes the drug and a 2 position code the mode of administration: CL = Clysis EN = Ear/Nose IM = Intramuscular IV = Intravenous		

Record Type 71 - Home Health Certification and Plan of Treatment - Data Definitions and Codes

Data Element	Definition	Field	Cross Reference HCFA-485
Medications (Cont)			
Drug Mode(Cont)	OP = Opthalmic PO = Oral SQ = Subcutaneous TO = Topical Ex. A01PO		
Dosage	1 to 4 postion code indicating the amount 1-9999. A 1 to 2 position standard abbreviation indicating the measurement: cc, gm, mg, ml, gr, gt, l etc. ex. 250 mg		
Frequency	3 position code indicating the frequency. Positions 1-2= nn-01-99 or QN-every N period (e.g., Q6H) Position 3 is coded: H = Hour D = Day W = Week M = Month		
Indicator	A code indicating new or changed medications. N = medications which are new orders (i.e. within the last 30 days). C = change of medication dosage, frequency or mode within the last 60 days.		

Record Type 71 - Medical Update and Patient Information - Data Definitions and Codes

Data Element	Definition	Field	Cross Reference HCFA-486
Mental Status	1-2 codes describing the patient's mental condition. 'Other' is described in Record Type 73. 1 = Oriented 2 = Comatose 3 = Forgetful 4 = Disoriented 5 = Lethargic 6 = Agitated 7 = Other	29-30	14
Prognosis	Code indicating physician's prognosis for patient. 1 = Poor 2 = Guarded 3 = Fair 4 = Good 5 = Excellent	31	20

Record Type 72 - Medical Update and Patient Information-
Data Definitions and Codes

Data Element	Definition	Field	Cross Reference HCFA-486
Place of Service Indicator	Code indicating if place of service is a nursing home. If yes, name and address of NH will be shown in Record Type 74. 1 = Yes 2 = No	4	8
Additional Care Indicator	Code indicating if additional care is being paid for by other than Medicare. Do not indicate yes for cases where Medicare is secondary payor. If yes, provide explanation in Record Type 74. 1 = Yes 2 = No	5	11
Dates of Last Inpatient Stay	From/To dates of most recent inpatient stay	6-7	12
Type of Facility	1 = Hospital 2 = SNF 3 = ICF 4 = Other	8	12
Date Physician Last Saw Patient	Date (if known) that patient was last seen by physician	9	13
Specific Services and Treatment	Description of type of visits (i.e., discipline) total number of visits by type, frequency and duration of visits by type and treatment ordered by the physician for the period covered by the plan of treatment. If applicable, shows number of visits on related bill covered by orders in a prior period.		

Show type visits in ascending order. Show frequency with related duration in descending order. Show all type visits ordered which are coverable by Medicare, including any covered by supplemental plans of treatment. To the extent that all type visits fields are not used, repeat a type visit when more than 3 frequency/duration fields or 3 treatment codes are needed. Otherwise show only the 3 highest frequencies with related duration and/or 3 treatment codes. Where a type visit is repeated, show only the frequency and duration and/or treatment codes in excess of 3. All other fields for that type visit must contain zeros or blanks.

Record Type 72 - Medical Update and Patient Information - Data Definitions and Codes

Data Element	Definition	Field	Cross Reference HCFA-486
Type of Visits Requested	Code indicating type visits ordered by physician 1 = SNC 2 = PT 3 = ST 4 = OT 5 = MSS 6 = HHA	10	14 Column 2
Number of Visits	Total covered visits by type expected to be rendered during the period covered by the plan.	11	14 Column 1
Frequency of Visits	Code indicating frequency with which type visits will be rendered. 1 = Daily (5-7 days per week) 2 = Twice daily 3 = Weekly 4 = Twice a week 5 = Three times a week 6 = Four times a week 7 = Once a month 8 = Twice a month 9 = Three times a month 0 = Once every period where frequency is less often than monthly. A = Three times daily B = Four times daily	12	14 Column 4
Duration of Visits	Code indicating length of time type visits will be rendered at the frequency shown. Code is a two position numeric which is an expression of days or a two position alphanumeric nx. n = 1-9 x = d-day w-week m-month	13	14 Column 4

Record Type 72 - Medical Update and Patient Information - Data Definitions and Codes

Data Element	Definition	Field	Cross Reference HCFA-486
	Example: Field 12 = 1, Field 13 =10 (Visits are daily times 10 days) Field 12 = 0, Field 13 = 2M (Visits are once every 2 months)		
Service and Treatment Codes	Codes describing the treatment ordered by the physician. Show in ascending order. Valid codes are: A01-A27 = Skilled Nursing B01-B15 = Physical Therapy C01-C07 = Speech Therapy D01-D04 = Occupational Therapy E01-E06 = Medical Social Services F01-F15 = Home Health Aide	18-20	14 Column 5
	Relate treatment codes to type of visit. Ensure that one or more codes are present for each discipline (i.e., SN, PT, etc.). Give priority to codes requiring most frequent visits. In addition, for HHA visits _if_ a bath is being given it is not necessary to show F4, F5 or F7.		
Number of Visits on Bill Ordered in Prior Period	Show if applicable the total number of visits by type on the related bill ordered by physician in the prior cert/recert period.		
Number of Times Patient not at Home When Agency Visited	Code 0-9	27	17B

Record Type 72 - Medical Update and Patient Information - Data Definitions and Codes

Data Element	Definition	Field	Cross Reference HCFA-486
Frequency With Which Patient Leaves Homes for: **Medical Reasons** **Nonmedical Reasons**	**Code indicating frequency patient regularly leaves home for medical and nonmedical reasons.** 0 = infrequent (i.e. less than monthly) 1 = daily 2 = twice daily 3 = weekly 4 = twice a week 5 = three times a week 6 = four times a week 7 = once a month 8 = twice a month 9 = three times a month	**28-29**	17C
Able and Willing Care Giver Available	1 = Yes 2 = No If yes, provide explanation in Record Type 74.	30	18
Supplemental Plans of Treatment on File	1 = Yes 2 = No If yes, provide explanation in Record Type 74. Covered visits, treatment codes, frequency and duration must be reflected in the applicable fields.	31	20

Record Type 73 - Plan of Treatment/Medical Update Narrative

This record(s) contains narrative information from the forms "Home Health Certification and Plan of Treatment" and "Medical Update and Patient Information." A separate 73 record will be generated for each of the following narratives:

Narrative	Data ID Number
Significant Clinical Findings	01
Physicians' Orders	02
Updated Information	03
Reason Homebound/ Functional Limitations	04
Rehabilitation Potential/ Goals	

The sequence number will be incremented by one for each 73 record which is present (i.e., 01-99). Use additional 73 records if necessary. A narrative must be present to document significant clinical findings and reason homebound/functional limitations/rehabilitation potential/goals. Physicians orders are required to give information not covered by treatment codes contained in RT 72. Updated information is required when significant events have occurred which are not documented in clinical findings or elsewhere in the records.

RECORD TYPE 73 - PLAN OF TREATMENT/MEDICAL UPDATE NARRATIVE-DATA DEFINITIONS AND CODES

Data Element	Definition	Field	Cross Reference
Significant Clinical Findings- Data ID 01	Describe succinctly clinical findings pertinent to the care being rendered. Include (only if the contact was nonroutine), the date (MMDD)you contacted the physician and the reason.	5-6	485(Item 19)
Physicians' Orders Data ID 02	Show specific physicians' orders. Do not repeat information described by treatment codes. Ex: Wound Care - NO Irrigate wound WH202 Apply DSD - YES Do not generate a record if orders are covered by treatment codes.	5-6	485(Item 12)
Updated Information Data ID-03	Describe succinctly pertinent information. Do not generate a record if there have been no new orders or notable occurrences.	5-6	486 (Item 15)
Reason Homebound/ Functional/Limitations/ Rehabilitation Potential/ Goals ID-04	Describe succinctly the pertinent information. Give explanation of functional limitations where necessary to further document homebound status or service(s) being rendered.	5-6	486 (Item 16)

RECORD TYPE 74-MEDICAL UPDATE AND PATIENT INFORMATION NARRATIVE-DATA DEFINITIONS AND CODES

Data Element	Definition	Field	Cross Reference HCFA-486
Additional Care Not Paid for by Medicare Service(s) Payor Source	Code for up to 4 services being rendered but not billed to Medicare where Medicare is primary payor. SN = Skilled Nursing PT = Physical Therapy ST = Speech Therapy OT = Occupational Therapy MS = Medical Social Service HA = Home Health Aide MO = Male Orderly Name of payor.	10-15	11
Available Care Giver	Describe type of care and frequency.	16	18
Supplemental Plans of Treatment	Show specialty, and services ordered. (i.e., SN, PT, etc.)	17	20

MEDICATIONS	CODE
A. Antipsychotics and Antidepressants:	
Chlorpromazine HCL (Thorazine)	A01
Fluphenazine HCL (Prolixin)	A02
Haloperidol (Haldol)	A03
Thioridazine HCL (Mellaril)	A04
Thiothexene HCL (Navane)	A05
Triflupromazine HCL (Vesprin)	A06
Amitriptyline HCL (Elavil)	A07
Doxepin HCL (Sinequan)	A08
Imipramine HCL (Tofranil)	A09
Chlordiazepoxide HC1 (Librium)	A10
Hydroyzine pamoate (Vistaril)	A11
Diazepam (Valium)	A12
B. Anti-inflammatory Agents (Nonsteroidal):	
Ibuprofen (Motrin)	B01
Indomethacin (Indocin)	B02
Naproxen (Naprosyn)	B03
Phenylbutazone (Butazolidin)	B04
Piroxicam (Feldene)	B05
Salsalate (Disalcid)	B06
Sulindac (Clinoril)	B07
C. Analgesics:	
Choline salicylate (Arthropan)	C01
Brompton's cocktail	C02
Codeine sulfate	C03
Hydromorphone HCL (Dilaudid)	C04
Meperidine HCL (Demerol)	C05
Methadone HCL	C06
Morphine sulfate	C07
Oxycodone HCL (Percodan)	C08
Pentozocine Lactate (Talwin)	C09
Propoxyphene napsylate (Darvocet)	C10
D. Anticonvulsants:	
Carbamazepine (Tegretol)	D01
Diazepam (Valium)	D02
Phenytoin Sodium (Dilantin)	D04
Primidone (Mysoline)	D05

MEDICATIONS	CODE
E. Skeletal Muscle Relaxants:	
Carisoprodol (Rela, Soma)	E01
Chlorzoxazone (Paraflex)	E02
Cyclobenzaprine (Flexeril)	E03
Dantrolene Sodium (Dantrium)	E04
Methocarbamol (Robaxin)	E05
F. Corticosteroids:	
Cortisone acetate	F01
Dexamethasone (Decadron)	F02
Hydrocortisone (Cortef)	F03
Methylprednisolone (Medrol)	F04
Triamcinolone (Aristocort)	F05
G. Antineoplastic Agents:	
Busulfan (Myleran)	G01
Chlorambucil (Lukeran)	G02
Cyclophosphamide (Cytoxan)	G03
Mephalon (Alkeran)	G04
Hydroxyuria (Hydrea)	G05
H. Antidiabetic Agents:	
Chlorpropamide (Dibinese)	H01
Tolazamide (Tolinase)	H02
Tolbutamide (Orinase)	H03
I. Topicals:	
Bacitracin	I01
Nitrofurazone (Furacin)	I02
Nystatin	I03
Silva Sulfadiazine (Silvadene)	I04
Desonide (Tridesilon)	I05
Flucinolone Acetinide (Synalar)	I06
Hydrocortisone	I07
Triamcinoline (Aristocort, Kenalog)	I08
Elase	I09
Wydase	I10
Granulex Aerosol	I11

	MEDICATIONS	CODE
J.	Drugs administered other than oral	
	Ampicillin inj.	J0290
	Bicillin C-R inj.	J0540
	Bicillin L.A. inj.	J0570
	Cefazolin inj. (Ancef)	J0690
	Diuril inj.	J1205
	Garamycen inj.	J1580
	Heparin inj.	J1640
	Imferon inj.	J1760
	Insulin inj.	J1820
	Kantrex inj.	J1850
	Lasix inj.	J1940
	Morphine inj.	J2270
	B12 inj.	J3420
K.	Diuretics:	
	Acetazolamide (Diamox)	K01
	Chlorothiazide (Diuril)	K02
	Chlorthalidone (Hygroton)	K03
	Furosemide (Lasix)	K04
	Hydrochlorothiazide (Hydrodiuril, Esidrex, Oretic)	K05
	Methyclothiazide (Enduron)	K06
	Quinethazone (Hydromox)	K07
	Spironolactone (Aldactone)	K08
	Triamterene (Dyrenium)	K09
L.	Electrolyte Balancing Agents:	
	Potassium bicarbonate (K Lyte)	L01
	Potassium chloride (K Lor, Kaon CL, Slow-K)	L02
	Potassium gluconate	L03
M.	Anticoagulants:	
	Dicumarol	M01
	Warfarin sodium (Coumadin)	M02

	MEDICATIONS	CODE
N.	Antibiotics (oral):	
	Kantrex	N01
	Neomycin	N02
	Cephradine (Anspor, Velosef)	N03
	Amoxicillin	N04
	Ampicillin	N05
	Carbenicillin	N06
	Cloxacillin	N07
	Dicloxacillin	N08
	Methicillin	N09
	Nafcillin	N10
	Oxacillin	N11
	Penicillin G.	N12
	Declamycin	N13
	Vibramycin	N14
	Terramycin	N15
	Achromycin	N16
	Panmycin	N17
	Sumycin	N18
	Gantanol	N19
	Azulfidine	N20
	Gantrisin	N21
	Chloramphenicol (Chloromycetin)	N22
	Clindamycin phosphate (Cleocin)	N23
	Coly-Mycin	N24
	Erythromycin	N25
	Furozolidone (Furoxone)	N26
	Lincomycin HCl	N27
	Cefadroxil monohydrate (Duricef)	N28
O.	Urinary Tract Antiseptics:	
	Methenamine hippurate (Hiprex)	001
	Methenamine mandelate (Mandacon)	002
	Cephalexin monohydrate (Ceporex, Keflex)	
	Nalidixic acid (Neg Gram)	003
	Nitrofurantoin (Furadantin)	004

	MEDICATIONS	CODE
P.	Cardiovascular System Drugs:	
	Digitoxin	P01
	Digixin (Lanoxin)	P02
	Procainamide HCl (Pronestyl)	P03
	Propanolol HCl (Inderal)	P04
	Quinidine	P05
	Erythrityl tetranitrate (Cardilate)	P06
	Isosorbide dinitrate (Isordil)	P07
	Nadolol (Corgard)	P08
	Nitroglycerin	P09
	Pentaerythritol tetranitrate (Peritrate)	P10
	Clonidine HCl (Catapres)	P11
	Guanethidine Sulfate (Ismelin)	P12
	Hydralazine HCl (Apresoline)	P13
	Methyldopa (Aldomet)	P14
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	Prazosin HCl (Minipress)	P16
	Reserpine (Serpasil)	P17
	Dipyridamole (Persantine)	P18
	Isoxsuprine HCl (Vasodilan)	P19
	Nylidrin HCl (Arlidin)	P20
	Papaverine HCl	P21
	Nifedipine (Procardia)	P22
Q.	Eye:	
	Bacitracin	Q01
	Chloramphemicol	Q02
	Erythromycin	Q03
	Gentamycin	Q04
	Polymixin B	Q05
	Tetracycline	Q06
	Tobramycine	Q07
	Blephamide	Q08
	Maxitrol	Q09
	Atropine sulfate (Isopto Atropine)	Q10
	Phenylephrine	Q11
	Artificial tears	Q12
	Hypertonic Sodium Chloride	Q13
	Timolol maleate (Timoptic Sol)	Q14
	Physiostigmine salicylate (Isopto Eserine)	Q15
	Pilocarpine hydrochloride (Isopto Carpine)	Q16

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A461. Special Instructions for Completion of the HCFA-1483 for Pneumococcal Pneumonia Vaccinations.—Effective July 1, 1981, Part B of Medicare pays 100 percent of the reasonable charges for physician professional services, and 100 percent of the reasonable cost for provider services for pneumococcal pneumonia vaccine and its administration to a patient if it is ordered by a physician who is a doctor of medicine or osteopathy. Neither deductible nor coinsurance applies.

The HHA must bill for these services, furnished on or after July 1, 1981, on a separate HCFA-1483 form which does not include charges for any other type of services.

For these bills the HHA must check the "other" block in item 9 of the HCFA-1483, and also enter the annotation "PPV." In item 15I, the HHA must enter the charges and a narrative description of the services.

The remaining items of the HCFA-1483 should be completed in accordance with the instructions in section 460.ff.

Cross refer: Sections 160.1B, 160.5, 219, 223.1, 223.2.

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CHAPTER IV

BILLING PROCEDURES

FOR INTERIM MANUAL INSTRUCTIONS

Section

Billing for DME Furnished As a Home Health Benefit .... IM 414

IM 414. BILLING FOR DME FURNISHED AS A HOME HEALTH BENEFIT

A. GENERAL

Medical appliances provided as a covered home health service prior to July 18, 1984, and billed in accordance with section 420, are reimbursable on a 100 percent reasonable cost basis. Section 2321 of P.L. 98-369 clarifies the definition of durable medical equipment (medical appliances) and requires the beneficiary to pay 20 percent coinsurance for DME. Effective July 18, 1984, medical appliances furnished as a covered home health service are redefined as durable medical equipment (DME) in accordance with the definition of DME contained in §220.1. Items which prior to July 18, 1984, could qualify as medical appliances under the home health benefit, but which would not meet the definiton of DME, may be covered if the requirements contained in HCFA-Pub. 11 §206.3B, which pertain to such items, are met. These covered items are also subject to 20 percent coinsurance. Medicare reimbursement for DME furnished as a covered home health service on or after July 18, 1984, is 80 percent of the provider's reasonable cost. The HHA may collect the 20 percent coinsurance from the beneficiary. DME furnished prior to July 18, 1984, and used beyond July 18, 1984, is subject to 80 percent reimbursement as of July 18, 1984.

B. REIMBURSEMENT

The amount paid to the HHA for DME furnished as a home health service is the lower of the reasonable cost of such equipment or the billed charges, reduced by the beneficiary's 20 percent copayment. Medicare reimbursement cannot exceed 80 percent of the reasonable cost of the DME provided. DME furnished free or at a nominal charge by a public HHA is reimbursable on a reasonable cost basis without regard to the lower of cost or charges. Public providers furnishing DME at nominal or no charge shall receive interim reimbursement equal to the number of covered days times the estimated reasonable cost per visit (see §2406.6, Part 1, Provider Reimbursement Manual). Coinsurance is applicable for DME furnished at a nominal charge.

For HHAs receiving periodic interim payments (PIP), the interim reimbursement will be adjusted appropriately in consideration of the 20 percent DME coinsurance. For HHAs not receiving PIP payments, coinsurance for the DME will be applied against the interim payment. If an HHA is inadvertently reimbursed 100 percent of the reasonable cost of furnishing DME under the home health benefit on or after July 18, 1984, the interim payment to the provider will be appropriately adjusted to offset the excessive payment. Intermediaries will make whatever interim adjustments bill data will allow. By necessity, some adjustments will be made during the final cost settlement.

C. BILLING

DME furnished under the home health benefit may be billed on the HCFA-1450, HCFA-1483 or the HCFA-1487. The intermediary will select one billing form to be used by all HHAs. All DME billed under these instructions must be identifiable for cost report and final cost settlement purposes. Regardless of the billing form used, the intermediary will generate a notice to the beneficiary to be used for payment of coinsurance by Medicaid and other supplementary insurance carriers.

1. HCFA-1487

HHA visit charges and DME furnished under the home health benefit are billed on the HCFA-1487. The coinsurance amount for DME will be shown in item 23B. If only nonvisit charges (DME) were incurred during the billing period, the charges will be included on the next bill which reflects a visit charge. (See §410.)

2. HCFA-1483

To utilize the HCFA-1483 for DME furnished under the home health benefit, the preparation of two separate bills, HCFA-1483 and HCFA-1487 is required. The HCFA-1487 contains all HHA charges except those for DME. The HCFA-1483 contains only DME charges. All DME will be excluded from the HCFA-1487 PIP or non-PIP interim reimbursement rate. The adjusted rate provides for proper Medicare reimbursement for all HHA services other than DME. A separate interim reimbursement rate based on a percentage of billed charges will be calculated for DME billed on the HCFA-1483, and coinsurance of 20 percent applied to the interim reimbursement prior to payment. To distinguish DME not furnished under the home health benefit, which is subject to 20 percent coinsurance and the Part B deductible, from DME furnished under the home health benefit which is subject to only 20 percent coinsurance, check box "A" in item 9 of the HCFA-1483.

3. HCFA-1450 and ELECTRONIC BILLING

Enter bill classification (2nd digit of item 4) 3 to indicate Part A billing. Revenue code 291 indicates use of DME. Enter a narrative description, or a DME code in item 50 to show the type of DME. Codes for DME will be shown in item 50 immediately to the left of the revenue code shown in item 51. Codes for DME will be furnished to you by your servicing intermediary. Interim reimbursement will be handled the same as billing on the HCFA-1487. Refer to §475 and Addendum C for HCFA-1450 bill completion instructions.

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REVISED MATERIAL	REVISED PAGE NOS.		REPLACED PAGES
Table of Contents Chapter I	1-1 - 1-2 (2pp.)	IES	1-1 - 1-2 (2pp.)
Section 157.3 - 165.1	1-21 - 1-26.1 (7pp.)	330	1-21 - 1-26.1 (7pp.)

NEW POLICY — EFFECTIVE DATE: (1) Clinical diagnostic laboratory testing — services provided on or after July 1, 1984.
(2) Durable medical equipment furnished as a home health benefit on or after July 18, 1984.

Section 160.6, Exceptions to Part B Deductible and Coinsurance.—This section has been reorganized and updated to provide a more complete listing of exceptions to the Part B deductible and coinsurance provisions including changes mandated by P. L. 98-369. The latter deal with preadmission diagnostic testing, clinical diagnostic laboratory tests, and durable medical equipment furnished as a home health service. Section 160.5 has been deleted since the material has been incorporated into this section.

There is no coinsurance for preadmission diagnostic services furnished during the period from December 5, 1980 through July 18, 1984, the date of enactment of P. L. 98-369. There is no coinsurance or deductible for clinical diagnostic laboratory tests and specimen collections furnished on or after July 1, 1984 where payment is on an assigned basis. However, there is a 20 percent coinsurance on DME furnished as a home health service on or after July 18, 1984.

MANUALIZATION — EFFECTIVE DATE: Not Applicable

Section 160.1, Benefits.—This section has been updated to provide a more complete listing of Part B covered services.

CLARIFICATION — EFFECTIVE DATE: Not Applicable

Section 160.3, Annual Part B Deductible and Coinsurance.—This section has been expanded to provide clarification on application of the Part B deductible and coinsurance.

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may be waived by the State agency. A facility primarily for the care and treatment of mental disease or tuberculosis may not qualify as a participating SNF in the health insurance program.

A patient can meet the prior stay requirement for "posthospital" home health services furnished prior to July 1, 1981 (see Chapter II) by a covered stay in a participating SNF. See § 155.3 for the conditions of a covered stay.

157.3 Benefit Period Defined.—A benefit period is a period of consecutive days that begins with the first day (not included in a previous benefit period) on which a patient is furnished inpatient hospital or extended care services by a qualified provider in a month for which the patient is entitled to hospital insurance benefits. (The term "benefit period" is synonymous with "spell of illness.") A qualified hospital (including a psychiatric or tuberculosis hospital) or SNF is one that meets all the requirements of the definition of such an institution. A hospital which meets the requirements described in § 157.1E and G is also a qualified hospital for purposes of beginning a benefit period when such hospital furnishes the patient covered inpatient emergency services. In addition, for purposes of qualifying for posthospital home health benefits, a benefit period begins with a stay in a hospital accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association even though the hospital does not participate in the Medicare program. Effective July 1, 1981, the prior inpatient stay requirement under Part A was eliminated. Generally, the benefit period begins when covered inpatient services are initially furnished to an entitled individual.

See § 210.1 for the benefit period as it relates to entitlement to posthospital home health benefits for services furnished prior to July 1, 1981.

The benefit period ends with the close of a period of 60 consecutive days during which the patient was neither an inpatient of a hospital nor an inpatient of an SNF. In determining the 60-consecutive-day period, begin counting with the day the individual was discharged. It is important to note that for purposes of continuing a benefit period, the hospital or SNF in which the stay occurs need not meet all the requirements that are necessary for starting a benefit period. Inpatient services will prolong the beneficiary's benefit period if the hospital is primarily engaged in providing, by or under the supervision of physician(s), to inpatients (1) diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for injured, disabled, or sick persons; or (2) psychiatric services for the diagnosis and treatment of mentally ill persons; or (3) medical services for the diagnosis and treatment of tuberculosis.

Similarly, inpatient services in an SNF will prolong a beneficiary's benefit period if the facility (including one primarily for the care and treatment of mental diseases or tuberculosis) meets at least the requirement that it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for injured, disabled, or sick persons.

An individual may be discharged from and readmitted to a hospital or SNF several times during a benefit period and still be in the same benefit period if 60 days have not elapsed between discharge and readmission. The stay need not be for related physical or mental conditions.

As long as a person continues to be entitled to hospital insurance, there is no limit to the number of benefit periods he may have.

EXAMPLE 1: X was born August 9, 1902. On July 28, 1967, X entered a participating general hospital. After he had been in the hospital for 2 weeks, X was discharged on August 11, 1967. On his doctor's orders, X entered a participating nursing home on August 15, 1967, and remained there until his discharge on October 27, 1967. He had no further inpatient stays in 1967.

X's benefit period began on August 1, 1967, the first day of the month he attained age 65 and was entitled to hospital insurance. The benefit period ended December 25, 1967, the end of the 60-day period beginning with the day of the last discharge.

EXAMPLE 2: Y, over age 65, entered a participating general hospital on July 28, 1968, for treatment of a heart condition. He was discharged on August 11, 1968. On August 20, 1968, Y entered a nonparticipating nursing home, which provided primarily skilled nursing care and related services. Y remained in this facility until his discharge on October 27, 1968. On December 25, 1968, Y was again admitted to a participating hospital because of injuries suffered in an accident. He was discharged on January 13, 1969, and had no further inpatient stays in 1969.

Y's benefit period began on July 28, 1968. His stay in the nursing home began less than 60 days after his hospital discharge and the spell was continued even though the stay was not covered. The subsequent hospital stay began less than 60 days after the nursing home discharge and continued the benefit period although the condition treated was unrelated to his prior stays. The benefit period ended on March 13, 1969, the end of the 60-day period beginning with the day of last discharge.

Supplementary Medical Insurance

160. SUPPLEMENTARY MEDICAL INSURANCE—A BRIEF DESCRIPTION

160.1 Benefits.—The voluntary medical insurance plan is designed to supplement the basic hospital insurance coverage. It provides coverage for home health visits and medical and other health services.

A. Supplementary Medical insurance covers unlimited home health services but see §160.5(B)(2) for exception.

B. Medical and other health services include:

1. Physicians' services (see definition of "physician" below) including surgery, consultation, and home, office, and institutional calls.

Regardless of the actual expenses for physician services incurred in the treatment of mental, psychoneurotic, or personality disorders of persons who are not inpatients of hospitals, the amount of such expenses that can be counted in a calendar year is limited to the lesser of $312.50 or 62.5 percent of the actual expenses.

Physician means a doctor of medicine, osteopathy (including osteopathic pracitioner) or podiatric medicine, legally authorized to practice by a State in which he performs the function. A doctor of dental surgery or dental medicine having State authorization to practice is also defined as a physician but only for surgery related to the jaw or any structure contiguous to the jaw, or the reduction of a fracture of the jaw or any facial bone. In general, "the jaw or any structure contiguous to the jaw" includes structures of the facial area below the eyes, e.g., mandible, teeth, gums, tongue, palate, salivary glands, sinuses, etc. With respect to certain specified treatment, a physician is a doctor of chiropractic legally authorized to practice by a State in which he performs this function. The services performed by physicians within these definitions are subject to any limitations imposed by the State on the scope of practice.

"Physicians' services" also includes services performed by podiatrists within the scope of applicable State licenses. This allows payment for certain foot care services whether furnished by a doctor of medicine, osteopathy, or podiatric medicine (to the extent that each is legally authorized to perform the services). Certain foot care services (including routine care), however, are excluded regardless of who performs them. (See § 232.9.)

A doctor of podiatric medicine is a "physician" for the purpose of making the required physician certifications and recertifications of the medical necessity for Part A and Part B services if the performance of these functions by a doctor of podiatric medicine is: (1) consistent with the policies of the institution or agency with respect to which these functions are performed and (2) consistent with the scope of the professional services provided by a doctor of podiatric medicine as authorized under applicable State law (§ 240ff.). A podiatrist is not a "physician" for the purpose of any of the physician activities required to qualify an organization as a home health agency (§§200ff. and 203).

Thus, a podiatrist may not be a "physician" member of the group of professional personnel responsible for establishing policies governing the services provided by the home health agency, nor may a podiatrist furnish any of the "physician" supervision of the agency's services required by the statute or Conditions of Participation for Home Health Agencies. A podiatrist is a "physician" for the purpose of establishing or reviewing a home health plan and satisfies the requirement that each home health patient must be under the care of a "physician." However, the performance of these functions by a doctor of podiatric medicine must be: (1) consistent with the policies of the institution or agency with respect to which he/she performed them and (2) consistent with the scope of professional services provided by a doctor of podiatric medicine under applicable State law.

For prosthetic lenses furnished on or after October 30, 1972, a doctor of optometry, legally authorized to practice optometry by the State in which he performs such functions, is a "physician" as defined in the law, but only for the purpose of attesting to the patient's need for prosthetic lenses. Thus, payment may be made for necessary prosthetic lenses (see 8 below) whether prescribed by an optometrist or other physician authorized to do so.

2. Services and supplies as follows:

a. Services and supplies (including drugs and biologicals which cannot be self-administered) incident to physicians' professional services and of kinds commonly furnished by a physician in his office and which are commonly rendered without charge or included in his bill.

b. Hospital services (including drugs and biologicals which cannot be self-administered) incident to physicians' services rendered to outpatients.

c. Diagnostic services which are (1) furnished on an outpatient basis by the hospital or others furnishing the services under arrangements, and (2) ordinarily furnished by the hospital (or others under arrangements to outpatients for diagnostic study). (See § 219ff.)

3. Diagnostic X-ray, laboratory, and other diagnostic tests.

4. X-ray, radium, and radioactive isotope therapy, including material and services of technicians.

5. Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations.

6. Rental or purchase of durable medical equipment (iron lungs, oxygen tents, wheelchairs, special beds) for use in the patient's home or place considered to be his residence.

7. Ambulance service, where the use of other transportation is contraindicated by the patient's condition.

8. Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices.

9. Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition.

10. Outpatient physical therapy and outpatient speech pathology services furnished by or under arrangements made by participating providers of services (including clinics, rehabilitation agencies, and public health agencies). This includes those Part B services furnished by hospitals to their inpatients who have exhausted their Part A inpatient benefits or who are otherwise not eligible for Part A benefits. Effective with services furnished on or after July 1, 1973, coverage of outpatient physical therapy was also expanded to include the services of a qualified physical therapist in independent practice when furnished in his office or the beneficiary's home; expenses incurred for such services in a calendar year may not exceed $100 for services rendered prior to 1982 and $500 for services rendered on or after January 1, 1982. (See § 219ff. for home health agency services which may be covered as medical and other health services.)

11 Pneumococcal vaccine and its administration; hepatitis B vaccine and its administration, and blood clotting factors for hemophiliac patients and their administration.

12. Certain medical supplies used in connection with home dialysis delivery systems;

13. ESRD composite rate for all outpatient maintenance dialysis items and services;

14. Antigens prepared by a physician;

15. Rural health clinic services;

16. Comprehensive outpatient rehabilitative services;

17. Ambulatory surgical facility services furnished in connection with certain surgical procedures;

18. Services furnished in a health maintenance organization by a clinical psychologist, a physician assistant, or nurse practitioner, and services and supplies furnished incident to such services.

Payment may not be made under Part B for services furnished an individual if he is entitled to have payment made for those services under Part A. An individual is considered entitled to have payment made under Part A if the expenses incurred were used to satisfy a Part A deductible or coinsurance amount, or if payment would be made under Part A except for the lack of request for payment or physician certification.

160.2 Basis for Payment.—Payment for services covered by medical insurance and rendered by a participating hospital, skilled nursing facility, home health agency, or other provider of services, or under arrangements made by such providers, is based on the reasonable cost of the services and is usually made to the provider of services.

Payment based on reasonable charges may be made to or on behalf of individuals covered by medical insurance for services of physicians and other medical and health services furnished under the program. In determining the reasonableness of charges, the carrier takes into consideration the customary charges of the physician (or other person rendering the service) as well as the prevailing charges in the locality generally made for similar services. A charge is not reasonable if it is higher than the charge applicable for a comparable service and under comparable circumstances to the carrier's own policyholders or subscribers.

160.3 ANNUAL PART B DEDUCTIBLE AND COINSURANCE

In each calendar year, a cash deductible must be satisfied before payment can be made under the supplementary medical insurance plan. (See §160.5 for exceptions.)

As of January 1, 1982, the deductible is $75.

From 1973 through 1981, the deductible was $60.

From 1966 through 1972, the deductible was $50.

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Expenses count toward the deductible on the basis of incurred, rather than paid expenses, and are based on the reasonable charge. Noncovered expenses do not count toward the deductible. Even though an individual is not entitled to Part B benefits for the entire calendar year, i.e., his insurance coverage begins after the first month of a year or he dies before the last month of the year, he is still subject to the full deductible for that year. Medical expenses incurred in the portion of the year preceding entitlement to medical insurance are not credited toward the deductible.

The date of service generally determines when expenses were incurred, but expenses are allocated to the deductible in the order in which the bills are received by the intermediary. Services which are not subject to the deductible cannot be used to satisfy the deductible.

After the deductible has been satisfied, providers will generally be paid the lesser of the reasonable costs or customary charges less 20 percent of the reasonable charge but no more than 80 percent of the reasonable costs, and physicians and other suppliers 80 percent of the reasonable charges, incurred during the balance of the calendar year. The patient is responsible for a coinsurance amount equal to 20 percent of the reasonable charges for the items and services. (See §160.6 for exceptions.)

160.4 Special Carryover Rule for Expenses Incurred Prior to 1981.—Expenses incurred in the last 3 months of a calendar year prior to 1981, which were applied toward the Part B deductible for that year, may also be credited towards the deductible for the following year.

NOTE: This deductible carryover provision was repealed effective with expenses incurred on or after October 1, 1981.

160.6 Exceptions to Part B Deductible and Coinsurance.—

A. The 20 percent coinsurance does not have to be met with respect to the following:

1. Purchased or rented used durable medical equipment (DME) including DME furnished as a home health benefit, if the charge does not exceed 75 percent of the reasonable charge of new equipment.

2. Preadmission Diagnostic Testing services furnished from December 5, 1980 through July 18, 1984.

B. Neither the annual deductible nor the 20 percent coinsurance apply with respect to:

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1. Radiology and pathology services furnished before October 1, 1982 to inpatients of qualified hospitals by physicians in the fields of radiology or pathology. (Services furnished on or after July 1, 1981, were exempt from the deductible and coinsurance only if the physician agreed to accept assignment for all radiology or pathology physician services furnished to hospital inpatients);

2. Part B home health services, except that there is a coinsurance of 20 percent of the reasonable charge for durable medical equipment furnished as a home health benefit on or after July 18, 1984. (See IM 414.)

3. Clinical diagnostic laboratory tests (including specimen collection fees) performed or supervised on or after July 1, 1984, by a physician, laboratory, or other entity reimbursed on an assigned basis,

4. Certain surgical procedures performed by a physician in an ambulatory surgical center or outpatient department of a hospital.

5. Ambulatory surgical facility services in ambulatory surgical center.

6. Pneumococcal vaccine and its administration furnished on or after July 1, 1981.

NOTE: Services which are not subject to the deductible cannot be used to satisfy the deductible.

Beneficiary Entitlement to Hospital Insurance Benefits

Sections 165 through 185 provide background information on entitlement. The social security office should be contacted if there is any question concerning an individual's entitlement under Part A or Part B.

165. HOSPITAL INSURANCE ENTITLEMENT FOR THE AGED (PART A)

An individual is entitled to hospital insurance (HI) protection beginning with the first day of the month in which he is age 65 or over and is entitled to monthly social security benefits (to be distinguished from supplementary security payments). Such entitlement also extends to aged qualified railroad retirement beneficiaries.

Hospital insurance coverage ends with the month the individual ceases to be entitled to such monthly social security benefits and/or ceases to be a qualified railroad retirement beneficiary. In the rare cases where HI terminates for an aged individual because of termination of his monthly benefits, he may obtain premium HI (described in § 168) by filing a timely application. Death also terminates HI; the HI coverage continues through the date of death.

165.1 Transitional Provision for the Uninsured.—Special provision was made to blanket in many older people who did not have social security insured status at the time Medicare began in 1966. Thus, aged people not entitled to HI by reason of being monthly beneficiaries could be entitled if certain prescribed requirements were met. Practically all persons eligible under this provision have already been awarded HI by this time; people attaining age 65 after 1974 must be entitled to monthly benefits in order to have premium-free HI.

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